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ABSTRACT

The collection of conference papers given by representatives of State, Federal, and voluntary agencies, and university faculty, discusses information and planning strategies aimed at maximizing independent living for the elderly. Introductory and welcoming remarks by James A. Thorson, Virginia Smith, and Frank Groschelle are included along with the full texts of the following papers: Advocacy for the Older Person, Carl Eisdorfer; Regional Directions in Serving Older Americans, Frank Nicholson; Action Toward Maximizing Independent Living for Older Americans; Ray Schwartz; The Role of the National Voluntary Agencies, Ellen Winston; Problems of Handicapped Older Citizens in Maintaining Independent Living, E. Percil Stanford; New Thrusts in Services, Goals, Barriers, and Some Solutions in Helping the Aged Toward Independent Living, James J. Burr; New Strategies for Serving Older People, Charles Wells; The Goal and Objective, Stanley Brody; Strategies to Identify and Serve the Target Groups, Margaret Blenkner; The Impact of Scientific Advances on Independent Living, Carl Eisdorfer; Services to Maintain Older People in Their Homes, William G. Bell; Strategies in Providing Services to the Elderly, Carter Osterbind. Working through the agencies of the Department of Health, Education and Welfare (DHEW), the National Voluntary Organizations, and regional and State programs is emphasized. (LH)

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ACTION NOW FOR OLDER AMERICANS TOWARD INDEPENDENT LIVING

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ACTION NOW FOR OLDER AMERICANS

TOWARD INDEPENDENT LIVING

Proceedings

ACTION NOW FOR OLDER AMERICANS

TOWARD INDEPENDENT LIVING

Edited by

James A. Thorson

THE UNIVERSITY OF GEORGIA

Center for Continuing Education

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Atlanta, Georgia

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PREFACE TO THE SECOND EDITION

In these days of rapid changes in knowledge and in our life style, the period of three years can seem like a long time. Remarkable things have happened since March of 1972, when this conference was held. American participation in the war in Southeast Asia has ended. War in the Middle East has come and gone, and at this writing we are seeing hopeful signs that warfare in Northern Ireland may be at an end. A President and Vice President have resigned in disgrace in separate scandals. The country's economy has entered the deepest recession since the Great Depression of the 1930s.

Dramatic changes have taken place in the field of aging since 1972, changes that were just on the horizon when this conference was held. The Supplemental Security Income program——a guaranteed annual income program for the aged——has come into being. The increase in funding for the Administration on Aging has been nothing short of remarkable. The Foster Grandparents program is now funded at a level higher than the entire Administration on Aging was in 1972. In December of 1974, the Labor-HEW Appropriations bill was signed into law, providing $105 million for state and community programs under AoA, $7 million for research, and $8 million for training. Since 1972 the Area Agency on Aging concept and the Title VII nutrition program have both been implemented. Also since 1972, there has been a $2.5 billion limitation on the amount spent for social services under Titles IV–A and VI (formerly Title XVI) of the Social Security Act. At the time of this conference, Title XVI still had an open-ended appropriation.

Other changes include the funding at a level of $14.9 million of a National Institute on Aging within the National Institutes of Health. Also, the House has approved revival of the popular HUD Section 202 housing program for the elderly. Gains in the levels of payment for Social Security, Railroad Retirement, Veterans, and Retired Federal Employees pensions have made real contributions to the lives of retired persons.

The more things change, however, the more they stay the same. We are pleasantly surprised that the proceedings of this conference are still useful after three years, as conference proceedings often are obsolete by the time they are printed. The new federal policy stated at this meeting of providing services as alternatives to institutionalization has not changed but has been strenghtened. Thus, this book has continued to have a high enough demand that we are making a second printing of it.

The field of gerontology has had a significant loss, as well, since 1972. Dr. Margaret Blenkner, who was then Director of the Chronic Disease Module Project at Michigan State University, died late in 1973. My last communication with Margaret was a letter dated July 9, 1973, about this conference proceedings:

Dear Jim:

Thanks for sending a copy of the proceedings of the Atlanta conference on Older Americans. You did a very good job and I'm quite satisfied with the presentation of my point-of-view. Incidentally, Watergate has hardly changed my mind!

Cordially,

Margaret Blenkner

Margaret refers in this letter to her suspicion of bureaucrats in general and Federal bureaucrats in particular. Her remarks on pages 42 and 43 of this document still are as fresh and biting as when she raised bureaucratic hackles all over the ballroom of the Sheraton-Biltmore when she made this talk on March 23, 1972. We dedicate this second edition of **Action Now for Older Americans** to her.

James A. Thorson
Athens, Georgia 1975

PROGRAM CONTRIBUTORS

Dr. William Bell is Director, Research Programs in Social Policy and Aging, Florida State University, Tallahassee.

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INTRODUCTION

"Action Now for Older Americans--Toward Independent Living" was a conference held March 22–24, 1972, at the Sheraton-Biltmore Hotel in Atlanta, Georgia. It was the first response on a regional level to the 1971 White House Conference on Aging. The conference was designed to bring together representatives of various state agencies concerned with matters of aging, selected representatives from federal and voluntary agencies in the Southeast Region, and selected university faculty as a means of providing the information and planning strategies toward the implementation of the national goal of maximizing independent living for older persons.

The meeting was sponsored by the Council on Gerontology and the Center for Continuing Education of the University of Georgia and co-sponsored by the Gerontological Society, the Southeast Federal Regional Council, and by the state commissions or offices on aging in the states of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

The reader will note the differences in style among the various chapters that follow. This is because contributors were given the option of either submitting a formal paper for these proceedings, which several did, or having the tape recording of their address transcribed. Thus, one will note the conversational flavor of a number of the chapters. We purposely did only light editing--completing sentences, adding punctuation--and therefore the reader has before him not a scholarly paper but a record of what was actually said at the meeting. What the remarks lack in polish, they make up for in spontaneity. We hope that the conversational tone has been preserved. We wanted to be very careful not to change the tone or the meaning of the things that were said, as some of the remarks recorded here are very good indeed.

From an editorial standpoint, transcribing from tape has its limitations. Talks by Frank Nicholson and Margaret Blenkner were largely in the question and answer format and cannot be reproduced here as the questions from the floor did not record well on the tape. We hope that not too much of the meaning of the meeting has been lost because of this.

The reader will also notice some similarity, at least in objective, to **Independent Living for Older People**, Carter Osterbind, editor, a Report on the Twenty-First Annual Southern Conference on Gerontology, held at the University of Florida, February 6–8, 1972. We attempted to coordinate our efforts so that the meetings in Georgia and Florida would be complementary rather than overlapping.

Dr. Arthur S. Flemming and Commissioner John Martin, both of whom were originally scheduled to address this meeting, unfortunately had to stay in Washington because of Congressional business. They were ably replaced by Ray Schwartz and Charles Wells, respectively. Charles Wells thus addressed the meeting twice. We have combined his remarks into one article.

Thanks should go to Virginia Smyth, Frank Nicholson, and David L. Levine for helping to make this meeting a success. Special thanks are in order for Marvin Schreiber, Director of Continuing Education of the Gerontological Society, who had enough faith in what we are doing in Georgia to support it with actual cash. Also, we wish to express our gratitude to Mrs. Lynda Whatley and Mrs. Linda Hames for their help in bringing this proceedings to publication.

James A. Thorson

WELCOMING REMARKS

Virginia Smyth

We are certainly pleased to have such a large group come in tonight for a conference which will officially open tomorrow. This meeting is hosted by the people whom you find listed in your program, including the University of Georgia Council on Gerontology, the Southeastern Federal Regional Council, and the state commissions and councils on aging. In addition, I think that there have been so many participants who have come together in determining what will go into this program that you could almost say everyone who is here is in some way responsible for this conference. The Federal Regional Council itself is comprised of a variety of federal agencies: HEW, HUD, OEO, Transportation, Labor, Law Enforcement, and Environmental Protection. Most of these departments or agencies are represented here tonight, as are their state counterparts, state councils on aging, state commissions on aging, various universities and colleges, and other programs. So what this really means, it seems to me, is that there are many, many people at this point in time who are excited about some of the new developments that are taking place in aging.

I would like to take just a minute or two to think about something. Perhaps I can relate this to welcoming, because certainly everyone who is here is indeed welcomed to this conference and to the opportunity for participating together in what I see as an entirely new outlook for aging. So I would like to take a minute to look at one or two of the milestones and to tell you about one of our losses at the same time that we are thinking about our gains. In the past ten years, since the first White House Conference on Aging, there has truly been an increasing recognition of the needs of older people, an increasing commitment to the meeting of these needs. We have recognized these commitments through a number of milestones. You know of the White House Conference on Aging back in 1961; out of that came the Older Americans Act and the establishment of the Administration on Aging. More recently we have seen the second White House Conference on Aging, and from that we have been blessed with some immediate results. We have received an increased appropriation for the Administration on Aging, and legislation in the area of nutrition is mighty close to being signed into law. We are hoping for new commitments for increased appropriations in the years ahead that will lead us into expanded efforts both in planning and services for old people. These are some of the things that have been real milestones as we move along. This conference will be dealing more specifically with the opportunities for all of us who are here tonight--and many others--to come together and work for the possibility that old people will be able to remain in their communities, be able to obtain a sense of dignity in old age.

Dr. Donald P. Kent, one of our colleagues whom many of you have known, died on Monday of this week from a massive heart attack. As I think about the milestones that we have had over the last ten years I cannot help but think of the real contribution that Dr. Kent made to all of this. He was one of my first bosses when I was working in the field of aging. He headed the Office of Aging and worked toward the enactment of the Older Americans Act and the establishment of the Administration on Aging; and at that milestone he recognized that he had reached a point where he could go back to the university which was his first love. He was a professor of sociology, a tremendous advocate for aging and for older

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people. If you worked with him, you could not help being touched--and being much better off as a person. I think it is fitting in this conference, when we are opening on the scene of advocacy for the older person, that we recognize that we have lost one of our treasured colleagues, one who was extremely active in the Gerontological Society and in all aging activities. I am sure, if he were here and joining us tonight as we move into a whole new area of work, he would be one of our strongest supporters and one whom many of you would want to call in for consultation to help you get the show on the road.

So while we will all miss Don for many years to come and recognize him as one of our finest and most beloved colleagues, I think there is no question what he would say: "Move on; I am delighted with the fact that aging is moving forward." So that is where we are tonight.

I am delighted to be here. I think it's going to be a fine conference, and we all hope to be working together even more extensively in the days to come.

ADVOCACY FOR THE OLDER PERSON

Carl Eisdorfer

The title I got when I was invited to speak here was a very impressive one, particularly since I am an absolute nut on trying to define terms. I think one of the great difficulties we have in our field is that we think we all talk the same language when in fact we really don't We use the same words, but they don't mean quite the same thing. What you are going to have to do is to listen to what I think advocacy is all about. I hope some of you will at least respond; if nothing else, I hope you know what I mean. I hope some of you will feel that some of these ideas are worth pursuing, because what I am about to talk about is not theoretical; I think it's pragmatic. I think that's what words have to mean. If they don't have any pragmatic application, then very largely they are wasted emotions.

Let me take the thesis prerogative and tell you one of the things that has bothered me for years. We have a conference title with the word "action" in it. That word has disturbed me because of another word. The other word which occurs to me when I see the word "action" is the word "active." Pretty obvious. When I see "active" I think of the opposite of that "passive." Now I think about a word like "action" and the planned word is "passion." I can never understand why "passive" is the opposite of "active" while "passion" means something entirely different. Remember that, because we may come back to it before the end of this meeting.

We are here to talk presumably about advocacy. (We will put down passive for the moment.) "Advocacy," as I have said, has lots of different meanings. Ralph Nader is an advocate. One of your speakers tomorrow is officially an advocate Commissioner Martin, you will find, is the advocate of aging for HEW; and if Dr. Flemming is here, he is also an advocate for aging. I asked these people what they do, and I got the following kinds of messages. It generally coincides with what lawyers are supposed to do, and that is where we got the term "advocate." It seems to me what they do, and maybe what we need to think about, is the notion of first developing arguments, second pleading the case, and third calling attention to something (argue for it or make it visible). All of this seems very reasonable. So my message to you is: Look, you've got to go out and be advocates. I am an advocate, and that's why I roam through the country and through Washington being an advocate. That's the part before Congress, and that exactly is what we do. We develop arguments about a situation. We plead the case. We make something visible. We call attention to it, and we argue for it. And thereby hangs the problem. I think as a result of advocacy we get caught up in an awkward situation.

I have a lot of mixed feelings about lawyers. You know, "some of my best friends" and all of that. But every time I get involved with a lawyer in a professional way, even if he's working for me, I always have a peculiar feeling--almost the same one as when I go to a physician professionally--about who he is working for. Is he working for him or me? It's particularly true of a lawyer because it seems that he always redefines what I have in mind. I go in with one set of ideas; but he's anxious to do a job, and by the time he's through doing the job it may not really reflect what I had in mind when I walked into that office at all. That's the second point I would like you to keep in mind along with the word "passion," because I would like to get to the third argument.

The argument is: advocacy for whom? Advocacy for what? In this case we have a very interesting problem because the target of all this advocacy that we now hear discussed and that we are going to spend the next few days talking about is **groups** of people.

A crowd advocacy, of course, is a big thing. Advocacy for the consumer, of course, is a major thing, and advocacy for the aged is really very big. So the aged are the target for all of this advocacy which is supposed to be a good thing. Well, is it?

I was behind another platform last week in Indiana, and Bernice Newgarten shared that platform with me. Bernice gave a talk which reflected some of her work at the University of Chicago, where she has done a considerable amount of work on stereotypes of aging.

Let me make a point here. Even though you all know it, we need to be reminded of it because I think it contaminates our role as advocates. I have heard these arguments used by all of us--and that includes me--because it's just very, very easy to fall into this. The argument simply is: when you start to advocate for this target group you suddenly find yourself somehow perpetualizing that all old people are poor, that all old people are agitated, that all old people are sick, that all old people have loss of memory, that they're rigid, probably a little senile, and so on. These old people need us; and, therefore, we are the advocates. Of course, nobody in this audience does it. But some people in the country who are exactly like you seem to do it.

Now, as I say, it's a compelling argument. It's easy to get people turned on to the notion that the old are poor, and so we sell the notion that all old are poor and in need of money. Indeed, we **know** that, depending on whose figures we use. It depends on who is keeping the statistics. Between 25 and 33-1/3 percent of the aged are poor. True, there is a lot of poverty among the aged; but it is also true that most of the aged are not below the poverty line. So we have to be careful about being advocates lest we sell the wrong idea, which is to imply that when we are arguing one point we may be losing another argument. When we argue the needs for medical care for older people--and Lord knows they need it--and say those needs should be delivered in a better way by many more educated physicians and nurses, it is true. But there are a lot of older people who aren't that sick, who don't really need all of that care. It is true that older people need transportation, and that transportation is a key to a lot of the difficulties we are having, but it is also true that many older people can drive cars and that some of them can even afford cars. And some of them can ride buses and can afford buses.

Now, why am I going into this? I am going into this because I think those of us who have been advocating for the aged have been in a peculiar way setting up a national image of aging which operates in disservice to many millions of older people. We have been advocating for older people, and as a consequence we have treated twenty million Americans as a target, as if they were one homogeneous mass of people requiring our services. Every bit of information we have says that older people are more different, more varied, than at any other time in life. The older you get, the **less alike** you tend to be. When we make the advocacy argument, I think we are arguing very often in the disinterest of a lot of people. I suspect this is exactly the opposite of what you expected to hear; but when I was arguing for advocacy I guess people said, "Yeah, but you are wasting your time." Now I am arguing for a different kind of advocacy, and I hope with this group of workers you will understand what I mean. What I mean simply is that we can no longer advocate **for** aged. Our advocacy must be **with** the aged. We can no longer talk about a homogeneous mass of people who need our help and ignore the people who are in fact able to contribute to their own well being.

One of the great failures we have is advocacy. We believe the image that we want. We have very often bought the stereotypes that I have just given you, and because we had them our attitude toward older people made us think they couldn't do without us. I am saying we have got to see the advocacy role in a very different way. I think we have to see our role not in terms of doing for, but in terms of making opportunities available. The major difficulty with the old in the United States

today is not just the absence of something specific like money or food or transporation; it's a lack of option. The lack of option is not corrected by giving older people those specific services in the abstract. If a person needs food and gets food, that's great; but you have really done very little unless you couple it with other kinds of help and involvement. You have done very little toward helping him become the kind of human being you would prefer to be.

Don Kent's death prompts me to suggest something. He and I were very close, and he was one of the people who influenced my career. We kidded about a lot of different subjects, but one of the things we talked about seriously at some length in Washington at the time of the international meeting four years ago was the business of the square curve. It seems to me everybody's desire is to have that kind of death, that quick kind of death. The truth is no one wants to grow old, and the truth is that one of the difficulties of being old is what I have customarily called the stink of death. Nobody really wants to deal with older people, and it's a lot easier to deal with them as objects than as people, easier to treat them as if they were an automobile that needs gas and reupholstery ever so often, than to treat them as if they were vital human beings who have a legitimate right to tell you what they need. That's the trouble with advocacy.

The reason I have done this turn about--and it is a very dramatic turn about--is because I know something that some of you don't know. Aging, since the 1971 White House Conference, has made an incredible turn. AoA was, at the time we went to the White House Conference, a roughly 26-million-dollar-a-year branch of SRS in the Department of Health, Education, and Welfare and a roughly 10½-million-dollar branch of NIH with a couple of thousand dollars here and there and a program in HUD.

The last I heard--some of this is fact, and some is rumor--AoA is at least a 200-million-dollar-a-year program; probably by July 1, it will be closer to 400 million dollars a year. It will be a center in the NIH. It will probably be another center in the NIMH. There is already somebody who sits in the secretary's office worrying about nursing homes, and people at HUD are tripping over themselves trying to get involved in developing programs for the aged. This is no minor miracle. It's a testimony to the beauty of democracy. Finally, somebody got to the president with this message and finally, because of the advocacy, we had impact, finally they are going to do something about aging. That's where the trouble comes in. Now for the first time we have the beginnings of the where-with-all to begin practicing what we have been preaching. And now comes the real problem. I won't make any allusions to the War on Poverty, which as far as I am concerned ranks only with the Vietnam War in its efficacy in this country. We are about to embark clearly on a new era so far as services for the aged are concerned. When I say we, I mean those of us in this room because, like it or not, we are sitting in very key positions. That's why the issue of advocacy has to be opened up and re-examined. Unless we shift our posture from advocating for this poor, deprived group of people who need our help to a cooperative role, to a development of the aged people working with us as partners, I think we will be promoting a disaster. We will be falling into the trap that led aged people in the United States to the peculiar position in which they find themslves, which is that of being a target. This position has generated the kind of agism that Paul Butler and Erdman Palmore have written about. We have to get agism out of the system.

So we can no longer think that doing things for older persons is the best thing in the world. I think we have to shift, we have to bend the professional structure, we have to modify a lot of the things we have been taught, and we have to do something that some of us are in fact doing but many of us have not really had the opportunity to do. I've talked in a lot of places about aging, and everybody asked me to summarize this. I summarized it by looking at the kind of closed-end quality to the life that aged people in the U. S. very often have. There are a number of social, physical, psychological, and economic changes that occur to them. We do find warehouses for the dying, a million older people in nursing homes, half of which are substandard. Still, that doesn't

characterize the aged, because there are a lot of affluent older people.

We really don't have good data on a lot of old people despite the fact that everybody thinks they know what old age is all about. More and more what you get the feeling for, particularly when you look at some of the economic reports, is: "Why consider the no-deposit, no-return thing?" We have come to a point in our society where the aged seem to be the waste, or the by-product, of the culture that we now have. Those of you who look at your soda-pop bottles will see, in the small print around the edge, "No Deposit-No Return." It is fine. It's very convenient. Right? You don't have to get involved in a complicated economical hassle over two cents for small bottles and five cents for big ones. All you have to do is drop it in the garbage can or put it in your compactor, and there's no worry about it. Of course, when it reaches the edge of town the sanitation commissioners have to worry about land fill and all these other things, and suddenly we discover that this great convenience turns out to be an ecologic disaster. We are finally discovering that our treatment of the aged has turned out to be a social and political disaster. This really raises the key issue, because the aged themselves, by and large, accept the nonsense of the stereotype.

One of the difficulties of being a minority group in our society--and this is true whether it's a language group, racial group, or, in this case, age-segregated group--is that we tend to perpetuate the myth partly because the target group believes the same myth. Working out in California a couple of months ago, I was told by some of the leaders of a special language community that these people believe what they're told. I think the black community learned that a couple of decades ago when they finally appreciated that one of the great difficulties in developing leadership was that the white mythology had somehow subverted the ability of the blacks to develop a coherent leadership. Only when they broke through that mythology did they get things going. We are just beginning to scratch the surface as far as aging is concerned--in terms of using the aged in their own best interest. Until the aged see themselves as participants in a society rather than as a product of a society, the concern that I have about advocacy, to the extent that we advocate for them and not with them, is that we are doing them more harm than good. And **them**, ladies and gentlemen, is **us**. We don't have, by and large, a square curve to our life pattern. We are all looking forward to old age. How would you like to age? What do you want done for you and what do you want to do for yourselves? Program your own job for that. What are you allowing older persons to do for themselves in your programs?

I talked earlier about playing the game of active-passive, action-passion. I think we need a new kind of advocacy. We need an advocacy with a passion, and the particular passion here has got to be participation. I don't like the notion that we are the representatives of a group of people who never voted for us, who don't really know what we are doing for them, and who are the grateful recipients of our bounty. We need to redirect our whole thinking in terms of involvement and development of people, including leaders in the community. I think we need action now, but not just what those of us in this room can develop alone. It must be action to involve people and to help them to set up a continuing involvement whereby they can again control their own lives. A long time ago when I got involved in studying and learning about people, people I knew used to say, "Isn't this terrible? You do all of this research and you see that older people don't learn as well as younger people, etc., but, you know, you are missing the point." I was younger and a little cockier then, and I never understood the point I was missing. They kept talking about wisdom. I don't want to make a big issue of wisdom. I am still not sure what wisdom is, but one thing I do know is that you don't get wisdom when you talk to a cocker spaniel and pat it on the head and the cocker spaniel wags its tail. Nor do you get wisdom by treating people that way--whether it's in a state hospital where everybody makes rounds and pats heads and gets smiles or whether it's the kind of paternalistic approach that we have in Senior Citizens Centers or whether it's the way we listen and nod our head and totally ignore a representative speaking for a group of aged people.

I am promoting advocacy. I think advocates are needed. I think we need more. I think we have been, by all standards, from all aspects, successful. I think we have every reason to believe we will be more successful. We have played the first role well. We have, in fact, developed the arguments and presented them to the American public. We know that there are now twenty million older Americans and that by the turn of the century there are likely to be forty million older Americans. We know that age sixty-five is an absolute nonsense criterion from a biological, psychological point of view, that it's only a bizarre circumstance of Social Welfare Legislation that sixty-five is a criterion of anything. There's no reason why sixty-four is young and sixty-five is old. I think we have made this point. We have pleaded the case. I think we have done a good job of it, but we have to do more of it. I think now we have reached the most important point of all. We have begun to get the where-with-all to go to the next level.

Now the question is one of control. Whom have we been the advocates for? As the resources go to us for the development of our own programs, perpetuating the internal structural myth, so that we have bigger and better agencies with less and less and less and less involvement of the aged people, I think we will have advocates for ourselves but not for old Americans.

WELCOMING REMARKS

Frank Groschelle

You know I get the opportunity from time to time to make welcoming remarks. "We are glad to have you" and that sort of thing. You have heard that so many times that I will skip to that very quickly. "We are glad you are here."

This week I have been in five major cities and it's only Thursday morning. I saw the sunrise over the Atlantic in Miami yesterday morning and was back in the office at noon. These are fast times. These are quick times, times when we who are responsible for programs that build the lives of people have to be more receptive and quick to respond. Therefore, I don't think anyone need necessarily apologize for the quickness in which we have asked you to come together because things are happening yesterday and today which affect the circumstances of aging in this country. One of the things that governments, plurally, at all levels, have been able to do throughout time is to respond to crises, respond to circumstances after they have happened. But government has failed **miserably** in anticipating what can happen. We have not looked very far ahead of us. We have not looked far behind us to see what kinds of mistakes we have made in the past. One of the initiatives that we in the federal establishment are taking today is the result of a couple of years of past effort; it's something called the Southeastern Regional Council.

I'm here with two hats. The first is that of the Regional Director of HEW, but the second is that of Chairman of the Southeast Federal Regional Council. It consists of seven agencies. It consisted of five until a recent presidential executive order added the two additional members and created the chairmanship as a presidential appointment. The interesting thing about those seven little members of the Regional Council, thinking about all the activities in which our communities and people are involved, is that those seven agencies constitute 71 percent of all the domestic expenditures that are made for activities carried out in communities in this country. It is significant that these seven agencies should be gathered together as a Regional Council with the primary purpose of providing a coordinative linkage to the expenditures that communities are making for their own self betterment: a new role, a new day in inter-governmental relations, a new day in the decision-making process, a new time for the transfer of power from the Potomac back to the people. We do talk about decision-making back at the level where people know of their problems and needs and are opposed to what we bureaucrats have throughout the years figured out that folks really ought to have.

The Regional Council consists of HEW, Housing and Urban Development, OEO, the Department of Transportation, the Department of Labor, the Law Enforcement Assistance Administration, and the Environmental Protection Agency. The latter two members are the two new ones.

A year ago, with some considerable effort and influence from Frank Nicholson and a little selling job that we carried to the Regional Council, the Regional Council accepted an initiative on aging as one of its priorities--perhaps the first and only time in this country that sevel federal bodies agreed to do one thing. A great deal of credit must go to Frank Nicholson and his continuous persistence. He has the tenacity of a bulldog. He hangs on so tightly sometimes that you have to bite him to get him to turn loose.

I know that this is going to be an exciting day for you. We suspect that there even might be a special

announcement later on today. We hope so. It is a time when your work load cannot get smaller. We have a great task ahead of us: to have everybody in this country in the mainstream of our social and economic circumstances. It is our responsibility to make sure that that particular initiative is carried out. Do you have a hang up? The number one country song now is called **Everybody's Got One**--referring to a hang up. Yours is aging, and that's where your expertise is. Continue to foster that hang up, because you will be able to make your contribution to the total ramification of people participation and people betterment in the Southeast and in the nation.

REGIONAL DIRECTIONS IN SERVING OLDER AMERICANS

Frank Nicholson

I do think the Southeastern Federal Regional Council is to be commended for taking some initiative and leadership and interest to provide for the activities and thrust that we have in aging. I do think that our leadership at the regional level consists of these various regional federal agencies, and they are to be commended for taking this kind of interest in older people. Mr. Groschelle mentioned to you that we have established in the Federal Regional Council a Regional Planning Resource Committee on Aging. We have representatives on that committee from the various agencies that make up the Council, with the exception of the two agencies that were recently named. We have representatives on the committee from HEW, HUD, the Department of Labor, the Department of Transportation, and OEO; and we will go after the other two very shortly. The purpose of our committee is to provide a regional base for planning, coordination, development, and evaluation services for older people in Region IV and the eight southeastern states, to begin a process of problem solving at national, state, and local levels with the public and voluntary agencies which will result in improving the quality and quantity of services, specific opportunities, and facilities provided to older people. This is in response to the priorities and policies which result from the efforts of the state and national White House Conference on Aging. It's our intent to establish a betterment of effort with state and local authorities in the pursuit of common goals for older people. We intend to mobilize regional and federal resources to relate to this effort.

For example, last week I had a meeting with key program people of the six agencies. We talked with them about our strategies and also to request their help in some specific areas. You know there are so many services that can be related toward the things we are talking about today. There is also an interest in identifying the various possibilities of federal funding for a wide variety of services in order to make this information available to states and localities as we move forward in the programs. That's an example.

We expect to relate to regional voluntary agencies as well. There are about twenty-five volunteer agencies that have regional offices. So from our regional point of view we are reaching out to involve the federal people at the regional level and the volunteer agencies. The Southeastern Federal Regional Council came to join together with the University of Georgia and the State Agencies on Aging in this Region in sponsoring this conference. The purpose of this conference is to bring together representatives of state agencies; we are talking here not only about the state agency on aging but also about representatives from state OEO, state offices on public welfare, public health, mental health, rehabilitation, state planning bureaus, agriculture, labor--these kinds of people. Selected representatives from the regional or federal and volunteer agencies and university faculties are a means of providing information about national goals and strategies being considered for achievement of these goals.

The particular goal to which the Federal Regional Council subscribes is the theme of this conference: making it possible for older people to live more independent, meaningful, and dignified lives in their own homes or other places of residence as long as possible, and to lessen isolation and to prevent unnecessary institutionalization. The conference agenda is structured to proceed from a rather general presentation and discussion about this thing to real

specific considerations of this goal, the target group, the programs which will be directed, the strategies, and discussions about these services that might be delivered. So from the general to the specific, we can begin to create an image of interests and an understanding, appreciation, acceptance, and support of the goal among the many public and voluntary agencies at the state and local level. While the main thrust of the goal is coming through the Administration on Aging and the Department of Health, Education, and Welfare, and through the State Agencies on Aging at the state level, it is a goal we cannot achieve alone. We need your help.

The state agency on aging is the focal point in your state for providing the initiative and leadership on matters such as these related to aging. As a result of the 1969 amendments to the Older Americans Act, State Agencies on Aging are responsible in their state plans and are recognized by various state officials and legislators as being responsible for statewide planning, coordination, and evaluation of services for older people. I think if you take a careful look at the ten objectives for the Older Americans Act--a copy of it was in the material you had--you will note that these ten objectives cover a wide range of human needs. Obviously, we recognize the necessity of having to work with other agencies toward achieving those objectives and that the resources that we have are by no means sufficient for us to do this ourselves. So, of necessity, we must involve and provide an opportunity to other agencies to work with us in this effort. Our State Agencies on Aging, in addition to statewide planning at the state level, have a responsibility for encouraging planning at the local level.

For the past several years our State Agencies on Aging and we in the Administration on Aging have devoted considerable time and effort toward preparing for the White House Conference activities. Out of some 6000 community forums conducted about a year and a half ago, this region had about 20 percent, about 1026. That's better than one per county. We had some 86 community conferences--one in each planning district in the region to develop policies that could flow into state and national conferences. We had eight statewide conferences and two regional conferences, so we have had an opportunity for the past year, with your assistance, to create a number of relationships at the local as well as the state level, in the public as well as the voluntary sector, and with citizens. We reached young people as well as old people because one of the requirements we had in our structure of the White House Conference was that we have two youth representatives from every state. So we feel we had a very successful White House Conference on Aging, perhaps the most successful such conference that I have heard about. We want to thank you people at the regional level as well as the state level for working with us on those activities, for making it a success. It's our success, ours together. I would like to say that we do appreciate your attendance here today.

You were very carefully selected. We were not after numbers. We were after quality and key leadership. I hope that as we proceed to move forward toward action for older people that you will continue to work with us. We need your support and help. We hope that you feel this meeting is productive.

As you might note on your agenda, if you made any comparison with the original material, from necessity we have had to make a couple of changes. Dr. Flemming, Chairman of the White House Conference on Aging, and Mr. Martin, the Commissioner of Aging, will not be with us because of the testimony that they are having to offer on Capitol Hill and because of some other activities taking place, but we have two good key people who work with them to make those presentations.

ACTION TOWARD MAXIMIZING INDEPENDENT LIVING FOR OLDER AMERICANS

Ray Schwartz

Dr. Flemming asked me to express to you his sincere regrets for not being able to address your conference here today. Recently Dr. Flemming was asked to testify before Senator Eagleton's Sub-committee on Aging of the Senate Labor and Welfare Committee, which is occurring about this time, and a little later in the day he has to participate in an event at the White House. Dr. Flemming does not take invitations to participate in meetings like this lightly. He always takes every opportunity he can to participate, but sometimes there are other priorities which make for a conflict which cannot be resolved.

I am delighted to be able to attend this particular conference. Early in 1970 I began work as coordinator for regional-state relations for the White House Conference, and the Region IV Conference in the spring of 1970 was the very first regional meeting in which I participated. It was a delightful experience then, just as it has been on several occasions since. I think of the various events that have been held at a regional level, whether they were orientation sessions for state executives and state chairmen, regional hearings, or regional meetings, and I think that the first one was always held in Atlanta. I do want to express to you something else that Dr. Flemming has expressed to me on a number of occasions, and that is the very high quality of work which is done by Frank Nicholson in this region. From my own point of view I appreciate very much the quality of organization that he has brought with his work, and Dr. Flemming holds him in extremely high regard.

There's a brief story which I have frequently used that is related to conferences, and it is really the first time that I have not been able to use it properly as applied to the White House Conference on Aging. The effect of the typical conference can be compared to the experience of one of the newly emerged nations of southern Africa which had to add a new word to its vocabulary. The word was "kumatmarata" and it meant, "to discuss at great length and appear to get nowhere." As I said, I used that to apply to many conferences because I frequently, honestly felt that many conferences resulted only in the proceedings being published and distributed to the participants. But at the White House Conference on Aging, we discussed at great length and **we did get somewhere.** We asked for action, and we got action. I think we got action, we got somewhere, because the White House Conference on Aging was not just a meeting. It was not just an event; it was a very careful and involved process that brought results. Literally hundreds of thousands of people were involved in the process of the White House Conference, and that involvement created or contributed to the success. The splendid work performed by the State Agencies on Aging which some of you represent, the work by private organizations, and by voluntary organizations, went together to bring us to the point where we are now.

Some years ago when I was working with an organization that was concerned with the physically handicapped, I heard a very amazing person give a very amazing speech. The man's name is Earl Shenk Meyers. He is an author and editor and also has a rather severe handicap from cerebral palsy. He loves to tell a story about when he was nine years old. His mother was very concerned about the obvious indications of what

then was not known as cerebral palsy but which was characterized by the doctor as a nervous condition. Earl was addressing a group of people who had been working with the physically handicapped for a number of years, and they were in a conference where they were discussing money, fund raising, public information programs, and this and that. He said to them very bluntly and very strongly, and in almost Biblical language, "the fire in your bellies has gone out." This cannot happen to us. The momentum that has built up the fire cannot go out.

I can give you some very good reasons why it will not go out. We had the process of the White House Conference and there were so many people involved that the public expects an accounting to be made. The mail which we receive every day and have received every day since the conference closed on December 2, is a strong indication of this. Much of the mail comes from older people, lay people who address Dr. Flemming in the following manner: "We were active in the White House Conference; we spoke out at the community forums; we participated in the community and state conferences, where we worked toward developing a national policy on aging." Sometimes we hear from people who attended the White House Conference Washington, and they say: "We expect some real progress to occur. We are not forgetting our participation. There must be an accounting." You know, as I do, that there were really more older people involved in the White House Conference of 1971 than had been expected. Ten years before, at the 1961 White House Conference, there were only some 250 people over 65. In the 1971 White House Conference, the median age of the participants was about 63. So we did have involvement from older people themselves, and they are continuing to look to us to see that the conference does result in positive action. There are, of course, more than individual letter writers who are concerned. A number of national organizations have announced and are organizing follow-up conferences to be held after the White House Conference. The American Association of Retired Persons is holding its biennial conference this year. The National Association of Retired Federal Employees is focusing many of its statewide meetings of membership on the results of the White House Conference and what is happening. The National Caucus on Black Aging is having regional meetings next month and a national meeting somewhat later. And at these meetings there will be a discussion of what has happened since the White House Conference.

Individuals and organizations are looking for an accounting. Where does the White House Conference stand right now? What is happening? We are in the process of extending the White House Conference. As you know, the conference was to be an activity extending over a period of several years but terminating this year, in June of 1972. There have been great expressions of interest in extending it so that it can do a more thorough job of completing its present work. We are in the process of having it extended for an additional six months, through December of 1972. So those of us who are still serving on the staff will not need to seek other employment until the end of this calendar year.

Dr. Flemming, as you know, has been named by President Nixon as his Special Consultant on the Aging and will continue in that role. In response to directions from the president, Dr. Flemming is organizing a post-conference board which will meet within about a month. The board will be composed largely of the people who served on the pre-conference planning board so well, and there may be some additions. This board has a very real responsibility. At the moment we are preparing material for the board to review at its first post-conference meeting. We have written every governor of every state and we have written every national organization that participated in the White House Conference, some 340, and asked them some of the following questions: Will you support all the recommendations of the White House Conference on Aging? If not, will you support a part of them? Which ones? Which ones do you give the highest priority to? In doing this, we hope to get a broad national reading from both the public and private sector of what is truly an order among the recommendations of the White House Conference. Once those responses have been received and we have, so to speak, synthesized and collated them, we will have them

reviewed by the conference planning board in order that we can be advised on directions to take during this calendar year. The conference planning board has a real role; it is not just a group of figure-heads. It plays a very active and helpful role through the entire process. A little later this spring, Dr. Flemming is going to participate in another series of regional meetings in each of the federal regional office cities, and I presume that many of you may be involved in these.

There have been some very interesting results coming out of the White House Conference, results we really didn't expect. Yesterday, for example, a gentleman, a Dr. Wolfe, called on me. He was for many years at the Chicago Theological Seminary and is well known as one of the leading Luther theologians. Dr. Wolfe is now working to develop retirement programs for the clergy. I took the opportunity to introduce him to Dr. Wilma Donahue on our staff, and the conversation they had wes simply fascinating. Out of this conversation they had, Dr. Wolfe was inspired to remark that he wants to devote some time now to developing course materials for young men and women studying for the ministry. Those of us who have attended theological schools usually can testify that the first experience we had with older persons was after we had graduated and discovered that our congregation had many older people who were isolated, who did not participate, who had withdrawn. There was a very real problem, and we could have done a better job had we been prepared. I think Dr. Wolfe is going to do something about this. And in response Dr. Donahue was moved to remark that it would be simply splendid if some older people--like herself, for example--would put on tape some of their real inner thoughts about growing old. For example, how often does an older person fantasize his own funeral? This is just one of the many examples she cited. I think that coming out of this she may develop a very interesting publication on the inner life of an older person.

The speaker last evening, Dr. Eisdorfer, mentioned a very interesting connection between words like active and passive, action and passion. Of course, during the White House Conference, Dr. Flemming and others had used the word "action" until it had become almost a part of the official vocabulary of the conference. I am thinking about action and passion, and it occurs to me that the real root meaning of the word passion is "to suffer." This, of course, is the lot of some of us as we attempt to carry out what is really a very difficult job. But if we work for action with all the passion we can muster, I am sure that we will succeed.

THE ROLE OF THE NATIONAL VOLUNTARY AGENCIES

Ellen Winston

Actually, the concern of national voluntary agencies with providing services for older adults is not new. What is new is the widespread active interest, including that of many organizations not previously identified with services for older adults, and the increasing programming of joint efforts.

Out of the local and state meetings which preceded the White House Conference on Aging there came repeated calls for specific services needed by older adults who could, with the availability of such services, remain in or return to their own homes. Because of the interest in such services across the country, Dr. Arthur Flemming took the steps that were necessary to organize the interested national voluntary agencies for concerted effort in encouraging the development of services in local communities. The history of this particular effort is well known to some of you but not to all, so I should like to sketch the major developments.

Dr. Flemming called together a small group to meet in Washington early last fall to consider at that first session the possibility of an organization which would focus on provision of homemaker-home health aide services. Both Mr. Nicholson and I were members of that initial group. It became evident that while homemaker-home health aide services are basic to both health and welfare areas, some interested groups would be concerned with other types of services involved in supporting older adults in their own homes, whether such services are taken directly into the home or need to be available in the community. The importance of the right of choice as to where to live was stressed. Following another committee meeting the more than 400 national voluntary organizations with some affiliation with the White House Conference on Aging were polled and asked to indicate whether or not they would be interested in participating in an effort to develop and strengthen services for older adults. The response was prompt and enthusiastic from a large number of national agencies, some of which had not previously been identified as organizations with special interest in older adults. This led to the development of by-laws and an organization which is really a steering committee of national voluntary organizations. Each voluntary organization has a representative on the steering committee to help guide the program. A smaller group, selected by lot, serves as an executive committee.

Initially 130 organizations indicated their desire to become affiliated with this steering committee with its clear focus on meeting a specific need. Since the White House Conference, seven additional organizations have become affiliated, and there are some seven or eight more organizations awaiting formal action by their boards--a truly remarkable response. Provision was made for a secretariat with the Administration on Aging carrying this responsibility in cooperation with the National Council for Voluntary Action.

Any organization has to have a budget. For the Steering Committee of National Voluntary Organizations the budget currently is a four-way proposition, including provision of staff services and certain perquisites by the Administration on Aging, provision of the part-time services of regular staff by the National Center for Voluntary Action, a grant from the Administration on Aging to the National Center for Voluntary Action for the employment of additional staff and other costs of doing business, and the costs of all individual participation borne by the individual national voluntary agencies.

As the first concerted activity, it was decided to promote meetings in some 300 communities of varying size and characteristics across the country to consider the needs of older adults in those communities, if the option of remaining in or returning to their own homes was to be facilitated. On the basis of criteria suggested by the steering committee at a meeting held during the White House Conference, these communities were selected and one or more conveners asked to call together a local meeting. If there were a Council on Aging or a Voluntary Action Center (VAC) in the community, the executives were usually asked to be co-conveners. In some communities where there was no known planning or coordinating group already in existence, a local person active in one of the national organizations was asked to be the convener. Representatives of the national voluntary organizations, of other interested voluntary groups in the community, and of public agencies were to be invited. Because of the tremendous amount of work involved in getting such a large scale activity under way, the letters to invite conveners actually did not go out until mid-January. Last week both the executive committee and the steering committee met in Washington to review what had happened since mid-January, and the results reported were not only encouraging but truly exciting. Of the 310 local communities which were finally selected, 203 are already actively participating; only 42 of the conveners have said they could not participate, and the reasons are such that we intend to re-check with some of these communities because perhaps the convener selected was inappropriate or tied up on other matters. Only 65 have not yet replied, and the time has really been quite short in view of the undertaking requested. As of last Friday, approximately 80 reports of the meetings already held had been received from communities ranging in size from one with 165 persons over 65 years of age to one with 168,000 persons in this age bracket (in other words, from a very small to a very large community). These reports are being carefully studied in terms not only of their content for the record but also for suggestions they contain for other communities and programs and the requests for assistance of some type. In many instances it will be necessary to help the local community learn about and take advantage of already existing resources.

At this point it is really too early to try to report on some of the things that have been started; but I know, for example, of one small community which is convinced through consultation with older adults that the next need is some type of meals on wheels program and that this will be organized promptly. In another community it was decided that the first need was a diagnostic clinic for older adults. Physicians were willing to start a clinic, but a paid secretary was essential. The organizing group went to the county commissioners and refused to leave until money was found to support the project. Out of your own experience in your states you can certainly add many illustrations. The illustrations I have given are small in themselves but are significant in terms of larger programs to follow.

The subject for this item on the program, of course, is "The Role of the National Voluntary Agencies." This they are continuing to define as a group, and they are already taking many steps to promote both specificity and cooperation. Most important is the use of their channels of communication to promote the objectives of the particular pattern of services essential to the support of continued independent living through telephone calls and letters to their regional and local affiliates and members, through the use of their newsletters, and through speeches and discussions at the various meetings which they sponsor. They have a major role not only in disseminating information about the objectives of the coordinated effort but also in educating their members about available resources. There is still widespread ignorance of public agency resources. The steering committee indicated last week that they also need to know about the resources of other voluntary agencies as they seek to make effective referrals. We have here a channel for really massive educational and informational efforts directed toward common objectives. Some of us were amazed at the large scale well-organized efforts already in effect which some of the steering committee members reported for their agencies.

The continuing role of the steering committee for the national voluntary agencies is an evolving one. The decision was made last week to continue to promote the community meetings and organizations in the initial group of communities,

to give follow-up help as indicated, and to evaluate what is being accomplished. Not the least of the accomplishments is to bring together in the community people, even with common interest, who have not known, let alone worked with, each other up to this point. The importance of a mechanism for simply bringing together people in communities, large and small, representing both public and private agencies, who should be working cooperatively is a major by-product.

Work will begin on the formulation of a second list of approximately 300 communities. We know that it is preferable not to approach this next effort on a crash basis but rather to look at the distribution of the communities presently involved and see that there is a real effort to fill in gaps, if there is a second group. Various members of the steering committee indicated that they knew of communities which were ready for this type of concerted activity and which they hoped would be included in another nationwide effort. Perhaps it is appropriate at this point to say that the cooperation from regional and state offices concerned with aging within the framework of the Administration on Aging has been excellent at every state. Only two states, Iowa and Missouri, failed to participate.

These early efforts have indicated the importance of agencies' understanding not only where there are public resources to be tapped but also the differing missions of major federal agencies. For example, at one point in the discussion during the recent steering committee meeting it was relevant to point out that the Administration on Aging has an advocacy responsibility, is charged with promoting the development of services, and is funded to carry out geographically and time-limited projects. On the other hand, the Community Services Administration, also within the Department of Health, Education, and Welfare, has mandated specific services for older adults in the public assistance area statewide and has available, on a 75 percent–25 percent matching ratio, open-ended federal appropriations for paying for direct services to individuals whether provided by the state or local public agency itself or through purchase of services. Through the steering committee secretariat continuing essential information of this type for many public programs will be disseminated.

There have been some beginning efforts in the steering committee to discuss the whole question of standards. What is needed in a community if we are to be able to say that older adults have available and accessible the pattern of services which they require and seek? Some people still think that each community has to determine and decide for itself what services are needed. Since we are talking about basic services, I firmly believe that the burden of proof that it does not need a specific service rests with the community. Study is a tested method for delaying action. We have only a few areas in which we have begun seriously to consider the quality and quantity of what is needed by older adults in the way of services which make it possible for them to remain in or return to their own homes.

Leadership in this area has been taken by the National Council for Homemaker-Home Health Aide Services. We are convinced that a ready measure of the adequacy of homemaker-home health aide services is one person available full-time for such services for every 100 persons 65 and over. This may seem totally inadequate to many of you. It does reflect the fact that any person or family regardless of economic status may need this service at sometime but that the service ordinarily is both time-limited and part-time. Perhaps in the smaller community which I cited with its 165 older adults, two homemakers would be reasonably adequate. However, in the larger community with 165,000 older people, it would appear that 1,650 homemakers would be the measure of adequacy. Also, the National Council has developed standards and is embarking on an agency review and approval program. It does us little good to promote services through national voluntary or indeed public agencies unless they meet reasonable standards and unless we provide protection to vulnerable individuals and families through the enforcement of standards. We have only begun, in the first stages of discussion of quality and quantity in most other areas of service, to facilitate older adults remaining in or returning to their own homes. Here is tremendous

opportunity for national voluntary agencies because they are looked to for leadership in their respective areas of emphasis. They can move more rapidly and flexibly than governmental agencies. Experience indicates, moreover, that on the average they will set substantially higher (but still practical) standards than will governmental agencies with the many stresses to which the latter must be responsive.

While this represents in essence where we have been able to come in these first three months as a steering committee of almost 140 national voluntary agencies, the future obviously holds tremendous potential. Organizations which could not do much alone have great potential through concerted effort. Organizations which mainly talked about programs are now urged to establish programs. I cannot really give you a blueprint at this stage with regard to the role of the national voluntary agencies on a continuing basis but can at least suggest some of the other directions in which I think you will find considerable emphasis as we move along.

There are, of course, various alliances of national organizations which support the provision of adequate income for older adults. With all of our talk about services, there is no substitute for this emphasis until we actually achieve a decent floor under the income of older adults, an income that is 25 to 30 percent below the still low poverty line. This is inextricably related to inadequate services since individuals must be able to purchase many items, including services. Our steering committee must cooperate in an effort to improve income levels. You are aware that there will soon be a drive to locate all older persons who are eligible for food stamps or donated commodities. This is certainly essential as an interim step, though it would be much better to provide money to older people so that they would not have to go through the often confusing mechanisms and the implicit attack on their dignity in utilizing either program. I do think that in the communities organized under the steering committee there will be much help given to this drive to see that there is full utilization of food stamps or donated commodities. There will be other programs which supplement income in various ways to which a special push can be given by voluntary agencies working together.

In a second area, we are already beginning to have questions raised about single service programs. We do not need to rediscover the wheel in terms of the greater efficiency for everyone concerned, both the providers and the users of services, of a multi-service agency. It is far superior to small, individual programs which national agencies working alone might support. While we promote the development of services, we need as a practical matter to be very conscious of the cost-benefit aspects. Where there are already on-going programs in institutional facilities, there should be a general approach across the country to adding to the already available service or services. National voluntary agencies are in a position to promote such developments.

Many people are concerned about day centers. Yet we have hundreds of residential facilities which could so easily reach out to the community in the provision of the kinds of programs which a well-formulated day center program provides. As another illustration, I have just read of a highly successful meals on wheels program where the cost per meal per person, including not only food costs but also personnel to prepare the meals, is $2.00 per meal. It would seem to me that it is common sense to evaluate the potential for helping older people get to a cafeteria or some other moderately priced establishment where the meal would cost less, where there could be choice of food, and where there would be the opportunity not only for the socializing aspects of bringing older people together but also for enjoying the younger persons who frequent the eating places. We simply must, through the combined efforts of the voluntary organizations, look for the various options for providing the desired results, for getting the most benefit from our services dollar.

A third area in which I think the national voluntary organizations must give leadership is in seeing that the essential components for a service are present in a home. You are all familiar with the old saying that a man cannot raise himself by his own bootstraps if he has no boots. A telephone

service program cannot meet the needs of the community if old age assistance recipients are not allowed to have telephones or non-recipients are too poor to pay for telephones out of their own resources. The national voluntary agencies are concerned that there not be complacency over having small programs serving a few people--really token programs in most communities today--but that specific programs be available to serve all older adults, community-wide, statewide, who would find them useful. The bits and pieces of programs we tend to boast of today are just a beginning and offer few choices.

In the fourth place, I believe that you will find the national voluntary organizations placing increasing emphasis upon programs designed to serve all economic and intellectual levels. Too many of our so-called senior citizens centers have programs which one retired professor disparagingly referred to as "chickenfeed." Isolation of persons needing and wanting to be in the mainstream are not limited to older adults with inadequate incomes or limited intellectual interests. We see, for example, that young people get to concerts and to other places where they will be enriched and stimulated. Why should we not have similar concern for older adults with programs that make possible continuation of lifelong interests or the development of new interests through leveling up what we are attempting to do?

Having already demonstrated in a beginning way the tremendous potential for national voluntary organizations to cooperate and to make their own members across the nation aware of both needs for services and resources for developing them, I would suggest that the role of the national voluntary agencies and their affiliates should be a major force as public programs are expanded. You need their help and support. They need your resources. The potentials for creative public-voluntary relationships that will result in a tremendous upsurge in meeting a wide range of the changing needs of older adults offer a challenge to us all.

PROBLEMS OF HANDICAPPED OLDER CITIZENS IN MAINTAINING INDEPENDENT LIVING

E. Percil Stanford

I am assuming that all persons in attendance are aware of some of the major problems older people have when attempting to live independently. My purpose this morning is to review the insurmountable problems the ill, handicapped, and minority senior citizens have when coping with the rigors of just plain living from day to day.

As reasonably well and not so old beings, we often tend to dismiss the apparent hardships of others by saying, "I'm sorry for her or him, but not sorry enough to stop and be of some assistance."

A great desire of many older people is to live in their own homes or apartments as long as they possibly can. It is human nature to want to be the master of one's own destiny. The American society is not at ease with the aged in its midst, and it has good reason not to be. In comparison with the elderly living in other advanced industrial societies, the old people of the United States live in greater relative poverty.

We ordinarily assume that a person, living in his or her own home, is able to get to bed at night, arouse himself in the morning, toilet and cleanse himself, obtain, prepare, and eat some foods, however simple, take necessary medications, care for a home in some elementary fashion, and keep track of and spend his money, however little. The truth is that many aged persons who want desperately to remain in their own settings are incapable of carrying out one or more of these functions even unsatisfactorily. I won't attempt to cover all of the problems or needs of older handicapped or disabled individuals who live or would like to live independently. I will only highlight some of those areas which tend to be major deterrents. The majority of these areas you are quite familiar with.

Poverty

Poverty is the way of life for three out of ten people 65 and over in contrast to one out of nine younger people. Out of every 100 persons, 65 and over, 57 are women, of whom 31 are widows. Twenty-nine are living alone or in the homes of others. Close to 60 percent of the older women living alone or with non-relatives live in poverty. Among non-white women living alone or with non-relatives, 85 percent live in poverty with another five percent on the borderline.

The minority older American does not have the equal opportunity for life, not to speak of the opportunity for a full life. The problems that confront the elderly in general confront the minority group elderly with a special harshness. In addition to their needs related to money, housing, and health, there are frequently the problems of alienation because of their cultural differences.

Transportation

The one looming barrier blocking successful independent living by the elderly according to many is transportation. In most areas, transportation is indeed a major problem. Not only food but also health and medical care, church attendance, cultural activities, recreation, and social contacts depend on adequate transporation facilities.

A reasonable assumption is that a lack of transportation is the single most important item that affects the older group when living alone; limited means of transportation prohibits shopping at shopping centers where older citizens might take advantage of lower prices, thereby forcing them to buy from neighborhood stores and drug stores. Medical services at reduced costs and surplus commodities issued by federal or state governments are useless if older people cannot reach them.

In most rural areas, public transportation has disappeared. Even where mass transportation is available, the cost of the fare is a problem for the poor, and the cost of taxis is prohibitive. It is a tremendous problem for incapacitated persons to walk to bus, train, or subway systems.

Generally, transportation services designed specifically for the aging are tremendously limited. Semi-invalid clients are usually without any transportation to physicians, clinics, and hospitals except that which is provided by relatives, neighbors, or members of a service organization.

Social Isolation

Isolation is a difficult situation for most persons at all age levels. The aged poor are the most vulnerable. Their age and associated physical disabilities make it difficult to keep jobs, travel, and participate in clubs and other associations; and their poverty and low levels of education make it difficult to be socially active because money for recreation, clothes, transportation, and other resources tends to be severely limited.

Housing

Housing conditions of the elderly disadvantaged continue to be a major obstacle for those trying to maintain independent living quarters. Thousands of elderly disadvantaged have continued to live in unsafe and unsanitary hovels. Current programs for elderly housing have not touched the needs of the elderly poor.

The problem of providing decent housing at a cost older people can afford to pay without allocating an undue portion of income to the cost of shelter has shown little progress toward solution. Housing units produced through public housing subsidy, long-term low-interest loans, and FHA-guaranteed financing have been insignificant in number in relation to need. One researcher (OEO by NCOA) shows that 32 percent of the older poor reported no inside lavatory or toilet, 29 percent no running water, and 56 percent no central heating.

Income

Most say they can use more money, and financial need is usually considered most important by those with lower incomes. This need is critical to the elderly since the majority have fixed incomes, frequently at a low level. Community residents should be aware of this problem and work toward preventing its continuance in the future. A simple solution to this problem is to attend to areas that consume the income of elderly citizens.

The magnitude of this problem is demonstrated by the fact that more than four million Americans of age 65 and up are statistically "poor." Without essential services, increases in income may be overtaken or even wiped out. The clearest fact of life is that disadvantaged older citizens must have access to more income resources if they are to move effectively toward independent living.

Medical Services

Our society has long been aware of the problems presented by medical services for the elderly. Medical services are often mentioned as a problem by all income levels. The problem becomes more acute for the severely disadvantaged and those in the lower income brackets.

An area of concern among a number of the elderly is hospital care. For many the hospital is close but transportation is not readily available; for others the hospital is just too far away. Perhaps the problem in this category can best be stated by

saying that "the medical delivery systems can be vastly improved and should be immediately re-evaluated."

Employment

Many elderly are not ready to retire at 62 or 65. Some would like to supplement their meager monthly incomes. Even with impaired faculties which hinder their effectiveness in some positions, numerous older citizens have a lifetime of valuable experience that could still be useful to society. It is unfortunate that we allow this resource to be lost to the community. Volunteer programs are useful but do not provide an income to those who need it.

Social and Recreational Activities

Handicapped senior citizens have special problems in participating in social and recreational activities when living alone. Their families are usually some distance away and their circle of friends and family have passed away. Social interaction is important and is often the key to overcoming or coping with handicaps.

Nutrition

That good nutrition is a problem for a surprising number of older persons has been well documented. Reasons given for this have been lack of financial resources, lack of knowledge about dietary requirements, and, recently, not being able to participate in an organized "hot" meal program. An important spin-off from nutrition programs has been that they have provided meals for older people in social settings so that they could gain friendship, social contacts, education, and activity as well as improvement of health through proper nutrition.

In addition to being poor, there are physical problems related to the lack of proper nutrition among the aged. Poor teeth and lessening senses of smell and taste may interfere with eating. It goes without saying that illness or physical ailments may prevent older people from shopping, cooking, and eating certain food.

Mental Health

Of particular concern are the **mentally impaired aged** living within the communities outside institutional walls. These are the old whose memory orientation and judgment are so faulty or whose perception of reality is so distorted that one questions their ability to perform effectively the simple chores of day-to-day living. These are persons who cannot manage their finances without spending too little money or over spending, who cannot negotiate with others to secure the necessities or to protect themselves from exploitation, who cannot maintain their habitats so as not to offend or endanger others, and who cannot control their emotions so as not to erupt in abusive or, more rarely, in violent attacks on others.

Although older people's mental health needs are extensive, the availability and adequacy of psychiatric care for older people is not. Although older people constitute 10 percent of the population, they account for 25 percent of mental hospital admissions. This statistic only serves to demonstrate the inadequacy of outpatient care for older citizens, not the elderly's incidence of mental illness.

Most old people retain normal mental health and general alertness throughout their lives, especially if they have interesting and useful activities to occupy them. Memory may be somewhat impaired, learning may be slower, but these are minor handicaps to which anyone can adjust. In 1960, it was estimated that about 5 percent of the 7 percent of persons 69 and over who would be judged as "certifiable" to a state mental hospital still lived in their own homes.

Conclusion We Can Draw

The fact that many older people remain in independent living situations is usually a matter of choice. As one retiree puts it, most older people have been used to being the masters of their households and do not want to answer to other people for their actions.

In spite of problems encountered among the aged who insist on living independently, research (Edna Wasser, Protective Services for the Aged) has shown that older people capable of remaining in their usual settings are more likely to survive longer. Satisfaction of ego needs of the individual combined with love and adequate income will be a giant step toward the goal of independent living for older Americans.

The problems are not the problem. We know what they are. The **problem** is for us to deal with the problems to help older citizens move toward independent living.

NEW THRUSTS IN SERVICES, GOALS, BARRIERS, AND SOME SOLUTIONS IN HELPING THE AGED TOWARD INDEPENDENT LIVING

James J. Burr

Since I have a limited amount of time to discuss the goal of independent living or self-care and how its achievement by the aged has been hampered in various ways, I would like to begin by asserting that I am talking about people whom we would like to see carry out the activities of daily living without anyone's help and exercise options as to current living arrangements to meet current needs. This is the kind of self-determination or mastery of living which most of us have more or less attained and retained in our majority and which most of us here enjoy.

Yet, while continued self-mastery and mastery over our environment is a continuing goal for all, we can recognize that, as we grow older, imperceptably, our physique, our reactions, our emotional and mental alertness fail; and we require different sorts of supports to help us to continue to carry out the activities of daily living without help from others. Obviously the settings or living arrangements in which we live contribute to independence in living, according to our life style, until such time as physical or mental dysfunction requires living arrangements which are appropriate or suitable to current capacities. In short, as a goal, independent living is good for many but not all.

I am interested in exploring independent living or self-care as a goal with you this morning since the Community Services Administration in the Social and Rehabiltiation Service and its predecessors have had this goal for many years for older persons in our program, along with other goals such as institutional care, community-based care, and self-support. This quartet of goals recognizes the continuum of living and, insofar as possible, provides for necessary supports from well-being to illness, along this continuum. Although I can take time to discuss only independent living and self-care as a goal here, what I have to say applies equally to the other goals.

As we see it, although limited numbers of clients will require institutionalization--that is, twenty-four-hour care in an extended care setting for those unable to manage in a community setting--most of our aged will be relying upon a variety of supportive social, health, housing, educational, and other services so that they can continue to maintain themselves in an independent community-based living arrangement.

In developing a national social service system, we visualize one in which, over the next decade, these characteristics will be prominent: equality of access; services to be provided to all who need them; definable social services which are also quantifiable, as well as goal-oriented; services which are multi-dimensional, available to individuals, families and groups in community settings; sufficient services to offer choices and options; services which are independent of and separated from income maintenance; services with common case management and service continuity components; a fee scale for services for individuals who can afford to pay; a service delivery system which is organized to provide services directly or through other means, such as purchase or compact; joint planning and budgeting with respect to general purpose government; and a system with fiscal and management components which provide for accountability and public disclosure on the one hand and provision for monitoring and evaluating the system on the other.

We see this system installed in every state in the union, serving millions of aged and other clientele. We are spending 1.8 billion now and expect to spend more later. If welfare reform passes, then we expect a substantial increase in the numbers served. The program serves three million now, will serve six million later and, ultimately, we hope, all of those older adults who need services. We expect this system to be effective, to demonstrate results, and to be capable of interlocking with other programs under the Older Americans Act, under the Vocational Rehabilitation Act, and with other systems, particularly the Health and Mental Health, Education, and Corrections system. States are even now developing such interlocks.

One massive problem which we have, among others--and which I want to discuss at some length with you--is that of overcoming barriers or obstacles which prevent older persons from fully achieving the goal of self-care and independent living. I refer not to physical barriers but to those administrative and legal barriers which arise out of policy procedures.

Barriers to independent living on the part of the clientele themselves have been discussed elsewhere in the meeting. Suffice it to say that such barriers should be an integral part of our consideration of obstacles and barriers to independent living for older adults.

Considering agency barriers, one needs to look at (1) the agency itself, (2) the agency in the service program grid, and (3) the agency as a component in a master-service plan.

There are limits on agency policies related to (a) group to be served; (b) services to be provided; (c) conditions under which services will be rendered; (d) the agency mission and its impact on how, where, and under what circumstances older adults live.

All of these factors are or can become barriers or obstacles to clients' efforts to secure agency services to help them to achieve self-care or independent living. Not only may a client need the particular service, but he may require that the service be provided to him at home rather than in the agency office. Agency policies which limit such outreach are obstacles to independent living. Again, the agency may exclude him from service. The agency may not offer services which the client needs. The conditions under which the services will be rendered may raise numerous obstacles to service. Such factors as areas of jurisdiction, or geographic coverage, the amount of staff time available, the factor of time-limited or short-term service versus long-term or continuing service or limitations of service which reflect discrimination are examples. The program mission in an agency serving several vulnerable groups may not provide the aged with an even break.

The factor of public agency or private agency may offer barriers to service. For public agencies, eligibility for service, based upon law, may deny service to one individual because of a technicality while another may be eligible. For private agencies, charter obligations may impose barriers to service. Sectarian private agencies usually limit their service to certain groups. Eligibility for service may be denied.

Barriers raised by limited funding are common. Anticipated services, the boast of the agency, may be curtailed if the agency does not have the funds. Thus, appropriation bodies (for public agencies) or financial or budget committees of parent funding organizations at agency or community levels may constitute barriers or obstacles to aged clients whose efforts at independent living may have to be curtailed because of reduction of assistance grants or limitations in anticipated services.

Another obstacle may be due to staff shortages in an agency or lack of trained staff or both. Anticipated benefits from counseling staff, educators, lawyers, doctors, nurses, etcetera may fail the client because the agency just does not have--and cannot recruit--such staff.

Attitudes of agency staff may provide obstacles or barriers to receipt of needed services because the staff either deemed that the client did not need the service or could not use it properly if it were

offered or refused to give it because the client was deemed "unworthy" of receiving it. Arbitrary and capricious actions of staff also fall into this category.

Agency actions which limit or restrict public information about their service programs or do not publish it widely or in words or in a language which is understandable to minorities may be obstacles to the client receiving needed services for independent living. Agencies which "oversell" their programs also fall into this category, since they cannot deliver.

The absence, in a public or private service agency, of means of an appropriate appeal, fair hearings, or grievance procedure whereby an agency client can appeal an adverse decision affecting independent living, is a real barrier.

An agency which has poor standards of care or of services is an obstacle to the client in achieving independent living. If an agency offering homemaker service sends an inexperienced worker who burns the meals, is dirty, and doesn't properly clean the house, this is an obstacle to independent living. Good accreditation policies with high standards for service staff will prevent this.

We have discussed the agency itself. Let's now discuss the agency in the service program grid. In this context we are moving away from the agency as an independent provider of a single service and considering the agency as one of a number of agencies necessary to provide a range of services which help older people to remain in their own home and avoid unnecessary institutionalization. In this context we are also getting into community obstacles to independent living.

Let's discuss several examples. One involves public agency relationships--the income maintenance agency, the social service agency, the medical service provider (utilizing resources of Title XVIII, Medicare, or Title XIX, Medicaid, of the Social Security Act).

Social services can never substitute for money. Money alone is not enough; for the chronically ill aged, medical care is a must. All three--social services, money, medical care--in concert are necessary for independent living. This, in effect, constitutes the tripod upon which the public assistance program rests.

This model has the potential to provide older adults with real independence in living. The reinforcement and linkage which social services afford financial assistance and medical care make this one of the strongest public service programs which we have available to serve the aged. Of course, the program can be faulted in terms of sometimes inadequate financial assistance or the inability to secure medical care because of the unavailability of a physician or for other reasons, or in the absence of a full range of concerted social services. What program cannot?

Yet the extraordinary flexibility of this service grid, despite the obstacles currently provided by insufficient funding, limited staffing, or narrow medical assistance benefits, makes it, when fully and appropriately used, under separation, an extraordinarily efficient tool to improve self-care and independent living in the aged.

Similarly, the planning grid, adopted by state commissions under areawide planning, involves the state and local committees on aging with other inputs, involves concerted actions by a number of public and voluntary agencies. Also, the mental health program service grid involves state mental hospitals, mental health clincis, and psychiatric wards of general hospitals.

Another example lies in joint and concerted actions between agencies, public and private, to help the aged to remain in their own home by the provision of a range of in-home services--some like counseling provided by direct service on the part of the public social service agency; others like homemaker services, home-delivered meals, home-health services, telephone reassurance service, chore services, and others provided through purchase agreements with voluntary service agencies.

This service grid, initiated by public service agencies in a number of places, has combined the concerted efforts of a number of voluntary

agencies, providing different services, along with the public service agency to help older adults to achieve self-care and independent living in community settings. Purchase of service agreements funded with federal matching at the 75 percent rate has allowed public service agencies to expand public services heretofore denied to the aged because of staff limitations in the form of numbers or qualifications or inability to fund services which now become possible. Such devices as unrestricted donated funds from other agencies are utilized by states to increase the state counterpart matching at 25 percent and thus earn additional federal funds to expand the program.

Thus, one obstacle--staff limitations in numbers and qualifications--was offset by purchasing services from local voluntary agencies. The other obstacle, absence of funds available to the public service agency, was overcome by new money donated without strings by private sources. In a number of cases these funds have been provided by the local United Fund agency.

Agencies planning to sell services to others should be prepared to provide:

(1) A clear and precise definition of agency mission, goals, and services provided and to whom.

(2) A clear explanation of any conditions under which services will be provided and any exceptions or exclusions clearly delineated.

(3) How much the services cost, including direct and indirect service costs.

(4) Willingness to conduct their own quality control studies of their service program or, alternately, to be prepared to submit their programs to review and evaluation by those who purchase their services as a guarantee of efficient performance.

This will tend to reduce obstacles in providing services to enhance independent living by clearly delineating the parameters and the framework through which social services are utilized to support independent living.

Now let us move to community obstacles to independent living--the function of the agency in a master service plan at the community or even the state level. If we are ever going to integrate services provided at the community level by a group of public and private agencies to promote effectively independent living and self-care, then we must reduce barriers and obstacles which can be identified, as follows:

(1) Barriers and obstacles raised by one agency's unwillingness to enter into concerted services agreements with other agencies due to its own charter responsibilities or to responsibilities under law even though its particular contribution is a vital core service and an essential component to a concerted services program.

(2) Resistance on the part of an individual agency or agencies to coordination by a local planning or funding body or an official planning body established by local government.

(3) Resistance to change on the part of existing service delivery systems.

(4) Obstacles to establishment of new service agencies by the community power structure.

(5) Unwillingness to raise public funds by taxation by county executives or boards of county commissioners to pay for expanded services for independent living.

(6) Unwillingness of united funding agencies to raise fund appeals to allow growth and expansion of existing service agencies or to start new ones.

(7) Unanticipated spin-offs of program areas which have themselves become priorities and which may take support away from the aged.

(8) Obstacles raised in communities by taxpayer associations towards the expansion and improvement of services programs for and on behalf of the aged.

There are others. This list, however, indicates the types and sources from which community obstacles to independent living arise.

Efforts to reduce such community obstacles which affect independent living by general purpose government have tended to consolidate under umbrella-type agencies--a number of public departments with similar goals and target populations, carrying out similar activities. Thus, in many communities, welfare departments, vocational rehabilitation agencies, youth services and offices on aging, offices for the alleviation of alcoholism and drug abuse, and offices catering to veterans have been combined in one overall department. This has the effect of establishing one single state agency with overall authority to make rules and regulations and to give program guidance and direction as well as consolidated administrative, fiscal, and budgetary managements of all the consolidated departments. Coordination, commingling of funds, and service integration are then possible, in principal at least. This has happened at both state and local levels. There has been little evaluation of how effective and efficient this overall integrated service program model has been in achieving announced purposes. In principal it should work. In practice size, program complexities in each program, lack of pre-planning to achieve overall objectives as between individual agency program goals, the latent effects of traditional ways of working which must be substantially modified, lack of trained and experienced supervisors, lack of coordinated reporting requirements, and simple unwieldiness of these program mixes may hinder the effective management of these composite organizations.

The private sector has had, over the year, a greater opportunity to experiment with coordinated service delivery due to the United Planning Organization. Limitation in funds over the last two decades has forced, through the budget process and agency self-evaluation, individual agencies to make individual concessions to joint planning and action agencies to achieve common purposes, particularly in the health and social service areas. This coordination has been accomplished with persuasion for the most part, backed up by the recognized ability of the United Way to deny funds, if necessary, to achieve goals which the community recognized and approved as priorities--the community, in this case, being the power structure. We do not have to agree with the priorities, but the methods have worked.

Today, we need to take another big step forward and work together to develop a national social service system providing community-level services, directly and through purchase, to the aged wherever they are. I would also like to add "whoever they are." Our hope is to move in-service provisions from current recipient loads to potential recipients, to all the poor and, eventually, to all older people. The use of fee schedules with cut-offs depending upon agreed-upon income levels reflecting dependency will help finance this expansion.

All this takes planning; it takes cooperative planning. Mr. Richardson, the Secretary of HEW, is committed to two things--greater coordination and integration of federal programs serving similar populations, having similar objectives, and carrying out similar purposes. He is also interested in making it easy for states to eliminate fragmentation in programs, particularly those which are federally funded. You can be sure that the secretary's priorities will influence federal directions in the social service areas.

It is appropriate to make some observations about the role of state commissions in reducing obstacles to independent living. Here are some guides (not necessarily in order of priority):

(a) Examine agency mission, purposes, and definitions of service. Learn what is being provided, how, when, where, and why. This is the origin of policies and procedures which offer obstacles to independent living to the aged.

(b) Analyze the obstacles by analyzing the reasons for their establishment. While these may be appropriate to the agency's purposes, some, considered individually, may be invalid in the context of the total community services structure. Eligibility determination may deny services to

otherwise eligible recipients (potentials). The solution is to reduce or simplify eligibility determination by changing the law.

(c) If the obstacle is based upon agency policy, try to determine the original intent of the policy. If valid, then identify alternatives which can maintain the intent without becoming an obstacle. The solution is then to change the policy.

(d) If the obstacle is based upon procedural requirements, determine if alternative procedures which accomplish the same purposes but pose obstacle are available.

(e) Many obstacles are based upon staff interpretation of policies and regulations. Challenge them. Class action suits in many cases undertaken by neighborhood legal service agencies have demonstrated how effectively such challenges serve to modify staff interpretation of policy which may be inaccurate, incorrect, arbitrary, or capricious.

Finally, as to funding, the potential of federal financial participation, particularly at the 75 percent rate, as an aid to state planning and community development and in expanding service delivery is enormous. Within a few years we have moved from about 25 million to 1.8 billion spent at the federal, state and local levels on social services, including hard services, soft services, and services for community planning and development. Under separation and with welfare reform and an open-ended appropriation together with the use of donated funds, we will be spending a great deal more.

This effort which we are making today, to begin to lay out on the table obvious barriers to independent living, is a very significant step. I hope that we will not let this be the end of this matter but the beginning of a direct effort to expose, in clear and definite ways, just what these obstacles are and how they hinder our efforts to help the aged in numerous ways beyond independent living, around protection, with regard to discrimination and particularly related to service access, and what to do to reduce or eliminate these obstacles.

We are committed to use our public service agencies in new ways to help people to achieve a better life, which is more engaged, better integrated, and fully satisfying. We know that you, too, are equally committed. Let's try it **together**; we'll **both** like it.

NEW STRATEGIES FOR SERVING OLDER PEOPLE

Charles Wells

First, let me say that Mr. Martin wishes me to express his regrets for not being here. He would very much like to address the group today, but he is testifying for a senate committee relative to the strategy I am going to be talking about in just a few moments.

The purpose of my talk is to give you a very brief run through of a proposed new strategy for implementation of the Older Americans Act. I advertise the word "proposed" because it is still but one strategy. It is embodied in a proposed period of amendments to the Older Americans Act. I know some of you have already heard this, but one advantage is that you are being kept up on the late changes because changes occur so rapidly.

Let me mention that this strategy also will be embodied in a presidential message that Mr. Nixon was due to release at noon. Of course, that could change, too. That message has been on deck and ready to release for several days, and hopefully by the end of the day there will be information in the news.

I would like to take a few quick looks backward. In the past four or five years we all have come a very long way. In 1965, by the initial passing of the Older Americans Act, we got a new program off the ground. Many, many community programs implemented a great new interest in aging which was never there before. That original Act and the Administration on Aging were by-products of the 1961 White House Conference on Aging. In 1969, there was a new direction for the older members of that program: emphasis on planning at the state level and area-wide programs on the local level. Now in 1972, there's an opportunity for a new generation of programs under the Older Americans Act. In the developing of strategy for continuing the Older Americans Act we have several objectives in mind. We wanted to make certain that the new program would be a program that could have a real and measurable impact on the lives of older people nationally. That is, it would be designed to achieve specific goals. We wanted to make certain that the development and delivery of services would be for those individuals who need such services the most. And we wanted to make certain that we worked with and utilized and built upon existing service systems already established around the country. We wanted all parts of the program to be inter-related and mutually supported. And finally, we wanted our program to be built upon our past experiences and our past gains.

Now, during the White House Conference on Aging, Mr. Nixon indicated that he felt the greatest need is to help more older Americans to go on living in their own homes as long as possible. And as you all know, the elderly themselves said, "We want the opportunity to lead an independent life in our own homes as long as possible." They don't want to be dependent on the community and upon their children. They want the opportunity to lead a dignified life. That is, they want adequate income to dress properly, to live in a decent house, to have normal social contact, to entertain themselves and their friends, and to eat properly. They want the opportunity to remain actively engaged in their community. They want to have the opportunity to work. They want to get about as needed. They want to have the opportunity to volunteer and help others if they wish to do so.

What is the reality of this situation? Many older people are independent. Many do live dignified lives. Many do remain actively engaged in the

community for years and years. But far too many older Americans live in isolation. Approximately five million older people, it has been estimated, live in isolation. They're home-bound because of lack of transportation. Let me ask a question that I have asked several times. When's the last time anyone here attempted to do all their grocery shopping walking? When's the last time you tried to walk to the doctor's office? And if the doctor said go to the hospital for a chest x-ray, when's the last time you tried to take public transportation to get there? The elderly don't drive. They can't afford the upkeep of a car; generally, insurance is too expensive or too hard to get. Further, in the area of isolation, no one knocks or calls for days; no one visits. Friends pass away and children move away. How many of us here have children living in other parts of the country? Too many older people are unable to be as independent in the community as they would like. Twenty-five percent of the elderly live below the line of poverty, and another fifteen percent live right on the very bridge of poverty. A single major expense is a crisis.

Too often unnecessary institutionalization is the only answer for many Americans. First of all, because services don't exist, the Administration on Aging has established the following goal for the implementation of the Older Americans Act. This goal is to assist older persons throughout the nation to live independent, meaningful, and dignified lives in their own homes as long as possible, with emphasis on the reduction of isolation and the prevention of unnecessary institutionalization. A major thrust of the program is to have a maximum effective use of existing resources and services for the elderly where they exist. A second thrust is the reduction of institutional barriers.

The major elements of our strategy include a strengthened federal capacity and role for the Administration on Aging, especially at the regional level. We anticipate between--but please don't hold me to this--fourteen and twenty federal staff people in the offices of aging at the regional level. Thus, through support and leadership, technical assistance can be provided on a continual basis. We anticipate a much strengthened state capacity for planning and leadership in aging. We anticipate between fifteen and twenty-five professional staff members in each state agency. We see a new effort to organize a local capacity for leadership, planning, advocacy, and program development in aging under the strategy. Finally, we see the development of comprehensive local programs on aging, especially in high priority geographic areas of the country. Emphasis is going to be on area programming, rather than on individual projects. We want to make certain that program elements are coordinated and supported and that every effort contributes to total effort to achieve the local goal.

I would like to turn to how we plan to implement such a strategy. Top priority and the implementation of such a strategy would go to planning. That is, we want the state agencies on aging and the local areas to make things happen on behalf of older people; to make things happen based on clearly defined ideas of needs. We want maximum effort on joint agency programs in the planning and implementation of the program.

Here is how, step by step, the program would be implemented: The first step is at the state level. Every year the state will develop a state operating plan on aging. Such a plan would establish goals on aging for the state and target groups of older people for special emphasis, areas within the state for priority programming, and an identification of local agencies on aging to be organized. Now, in the establishment of priority areas of the state, the existing boundaries of planning areas would be recognized wherever possible. It would make certain that the area selected would not conflict with existing planning and service areas within the state.

Step two is at the local level. There will be a local agency on aging organized to program throughout a priority area. The purpose of this agency would be planning, program development, leadership, and evaluation rather than the actual operation of programs. It would provide technical assistance and enter into agreements with other providers of services for the actual delivery of service to older people. The leadership of the individuals at the local level is the key to the success of the whole

strategy. That local agency would develop an area plan on aging. That area plan on aging would be designed to marshal the resources within the area for serving older people and to expand and improve existing resources and services and to get the elderly in need in contact with existing service systems. The plan would provide information on the total number of elderly in the area, for example. It would identify special needs of the elderly in that particular area, establish target groups to be served, and establish output-oriented goals for the program. It would identify resources of the area and seek commitments from existing service agencies for joint programming. It would outline a plan of activity and services to be delivered to meet the goals that have been established. Finally, it would identify additional resources needed to get the job done.

Such a plan could be funded by the state agency on aging. The plan that is developed could contain a wide range of needed services. However, we feel that certain basic service components are essential in every case: for example, a strong out-reach effort to make certain that there are no unknown older people in the area. Also, it must implement activities that connect older persons in need with services that are designed to meet that need. Such things as special transportation services, escort services, information and referral activities are examples. The plan could also provide for the delivery of nutrition services, nutrition in the home, and nutrition group settings. I would like to mention that, as you all know, Senate Bill 1163 was signed into law yesterday. So, if my information is correct, we now have a national nutrition program designed to provide meals to older people in a group setting, in home settings, with a variety of mutually supported and inter-related social services in transportation. You will hear more about that later.

A variety of different social services could be provided, services such as in-home, homemaker, friendly visitor, telephone reassurance, and community group services. In other words, there's no limit to the type of services that could be planned. However, the services planned for would be delivered by existing service delivery systems within the area, not by the local agency on aging.

We are asking in the delivery of this new program, if it is to become a reality, that special attention be devoted in the delivery of services to those older persons who need such services the most. We are thinking of the hard to reach, the isolated, the unknown, the withdrawn, those living alone, and those whose needs are outside the existing services. I won't go into great detail here because right after this I understand I have to talk about target groups so I will save something to be said about possible expansion and identification of target groups. We want to emphasize that the state agencies and the local agencies in the local areas will be the ones to identify the target groups to be served for special emphasis.

I would like to give you an idea of the range of resources that may be available to such a strategy if it were enacted. The number of resources that I am going to mention to you now are tentative and proposed, but they are levels that are going to be requested by Mr. Nixon for the implementation of such a strategy. For example, for state agency planning to strengthen and upgrade the state agency, a little over 12 million dollars annually is proposed, at least in FY73. For area planning--that is, the establishment of local agencies on aging--approximately 12 million dollars is expected, and we estimate that this will make possible the establishment of at least 300 priority program areas in FY73 alone. For area programming, that is, the resources available to the state agency to implement the plans that are developed by these local agencies would be somewhere in the neighborhood of 174 million dollars. The total would come to 200 million dollars. That's what is being requested. A certain portion of this total of 174 million dollars would be reserved on a discretionary basis to award to states and programs of especially high merit. I should also mention that there are plans--and I can't go into great detail here because I don't know the details--urging the concentration and emphasis of other federal agencies' resources in concert with these, if it is possible. I think that if the presidential message is made public today we may begin to see some of the details spelled out on such a strategy.

In summary, the strategy recognizes that this is a major expansion of our resources for practical purposes, from 21 million dollars under this program to approximately 200 million dollars. These resources are still limited. Therefore, they must be used strategically. We think that this plan would be a very strategic use of such resources for the opportunity of having the greatest impact on older people. Under such a strategy, we foresee the reduction of barriers preventing independent living, both institutional barriers and other barriers. There will be a decline in the number of older persons who are institutionalized each year unnecessarily as a result of a lack of supportive services in the community. There will be an increase in the number of private and public agencies that serve the elderly. There will be an increase in public and private agency resources to be directed at the needs of the elderly. We think that there would be great effectiveness and cooperation of existing service delivery systems. The unique and special needs of the elderly will begin to be taken into account in terms of long-range planning. Great cooperation and coordination between agencies can be realized because of the opportunities for joint planning and joint programming.

We feel that the strategy for proposed projects provides some very unique opportunities. It will be a very deliberate approach. That is, we will be going out to make something happen because it needs to happen. We recognize that no one agency or program can get the job done alone. There is the maximum opportunity for cooperative programming and a provision for the real integration of resources, both staff and dollars, in a very practical way at the local level. It gives us the opportunity to move ahead very dramatically, so that our new resources will be well utilized and, hopefully, magnified. We think about approaching the problem on a program basis and area basis rather than project by project. We have the opportunity of making sure we get the maximum return for the resources available. In addition to opportunities there are dramatic challenges, challenges to all of us, especially people like you in this room. People like you may determine whether such a strategy will be successful or not. The success of such strategy really lies within all of us. We must work together, and we can work together if we establish joint goals that are people-oriented. That is, we want to make something happen to people. We must learn to think big and bold. We must look to new ways, the best ways, to get the job done, whatever that job might be. Again, emphasis must be on what happens to people.

The Target Group

Before I turn to the topic of the target group, let me explain two things: regionalization and guidelines. I am permitted to decentralize the decision making process in this program to the maximum extent possible to get it closer to where the action really is. We are going to give Frank Nicholson major decision making authority, not only in your state plans and operating plans but actually in the award of the discretionary moneys. He and the staff he is going to have working with you for this program are going to be right on the firing line themselves. They are not going to have to depend upon the bureauracracy in Washington to react to a movement on your part to get going. So, again looking to Frank and Virginia, they are going to have the decision making authority of this program.

Now, in terms of guidelines, there **are** no guidelines right now, but there's a good reason for that. We don't have any authority to write guidelines or even issue them. We need an act. We need regulations, and those regulations have to be developed; and a very distinct process must be followed. That process includes printing the proposed regulations in the Federal Register, giving governors at least fifteen days to react to those regulations, allowing comments to come back to Washington, making changes, reprinting regulations in the Federal Register, asking the states to develop state plans, sending state plans to state clearing houses, allowing state clearing houses forty-five days in which to renew the plans. So there are a lot of procedures and processes. We are moving; we are developing tentative guidelines; we are moving forward to the strategy. And the state people in this region have been informed of our initial ideas. We are asking them for their

comments, because we really believe in getting input. We are tying to give you the tools whereby an effort can be made to get underway, but on an informal basis, so that when the word comes to move we don't start from scratch. Perhaps we are moving and we are trying to keep ahead of the game but we have to handle it very carefully.

My discussion for the next few minutes has to do with target groups. The question of target groups is a difficult one, because we just haven't worked out the details yet, and we just don't have all the answers, and we don't want to pretend we do. I would like to use this session then to share my initial ideas with you and ask that you share your ideas with us, because in splendid isolation in Washington we just don't have all the answers. You are the peopie that have the answers. You are on the firing line. You are working with older people.

I want to explain the reaction we get when we mention target groups. The question that most often comes up next is: "Are we talking about welfare recipients?" And the answer is: "No, of course not, nothing could be farther from the truth." I would like to suggest that perhaps the whole elderly population, all twenty million older people, are conceivably a target group.

Changes do occur in life. For example, there are major changes in our society, weekly, monthly, yearly. I am suggesting that perhaps added years on life make it a little more difficult to adjust to such changes. I think we all have trouble adjusting; I know I do. I am finding, with situations that occur in my family, with my own children, my daughter, with the music my daughter listens to now, that I have to keep reminding myself to be tolerant. My wife keeps telling me to be tolerant. Perhaps, though, there comes a time, after a life of adjusting to change, or perhaps fighting change, where we give in to change. I don't know if that's possible, but perhaps it is. Not only does change occur in society or in the immediate environment in which we live, but also within ourselves. We have changes in our health, changes in our mobility, changes in our income, changes in our attitudes towards life. This change does occur. What I am leading up to is that I don't think we can put the elderly into a mold. They just don't fit. It depends upon where you live or whether you live alone or in family settings--that is, with a wife or a spouse. It depends upon whether you are in good health or poor health, whether your wife just died, or whether you are happily married, whether you have an income of $1200 or $12,000. Again, some people are young at seventy while others are old at forty. Changes do occur, and I think the elderly are often most affected by change.

The attitude of an older person toward himself and his needs can vary from day to day. In other words, you ask him, "What's your problem today?" His attitude can really be quite different next year, or next month, or next week, or even next hour. Changes can occur that quickly and can have a very dramatic impact on life. In any given moment, in a community, there are older people who do not need help, who do not want help; but at the same time, there are those who do need help and would very much like to have help. I am suggesting that those who say today, "I don't need help and I don't want it," might be in a different situation next week. We really believe in the Administration on Aging that the elderly deserve an opportunity, that when a need does arrive there should be the potential to react or respond positively to that need.

Within the total elderly population, let's run through a list of people we might want to provide special emphasis on; and there's quite a list. For example, there are older people who do not have needful social contact, contacts with friends, family members, neighbors. There are older persons who live alone and who are isolated through illness and handicaps; they're deaf, or have poor hearing, or they have very poor vision--that's a real handicap, enough to isolate an older person. The fear of violence or the fear of crime is another problem. Attitudes can be very, very important in isolation. There are older persons who are alone and isolated due to inability to drive or who are too far from public transportation. Public transportation may have been discontinued, and the cost of a taxi is far too excessive.

There are older persons who, because of physical or mental deterioration, are in need of supportive and protective services. Some older persons have involuntarily been moved out of familiar neighborhoods due to urban renewal and relocation. There are also older people who have relocated themselves voluntarily and find themselves unable to adjust to their new home and their new environment. There are ambulatory older persons in housing projects and homes for the aged who have become ill or disabled and have become isolated and confined to bed; and there are frail older persons in need of some supportive services to help them remain in their own homes. There are older persons in nursing homes and institutions who lack community support and reassurance for re-entry into the community. There are older persons in nursing homes or institutions who are isolated from the community due to the lack of relatives, friends and neighbors who visit. Finally, there are just homebound older people who need a contact with someone who cares, a social contact to see that they get food--or just friendly visiting. I know that's quite an extensive list, and it ranges across quite a group of people. However, how many of our existing programs serve these kinds of people? Their need is really great, but it is for these people that many of our existing service systems are really inaccessible. The services are there, but those who need them can't get to them and can't make use of them. Yet their need is great.

I am suggesting that certain groups of older people could be identified as target groups for special emphasis. They could be sought out, and provisions could be made for involving them in our programs and our services. I know it's difficult. We are asking for the tough job. It will involve things like an extensive outreach service, special transportation, friendly visiting, telephone reassurance, and escort service. I am suggesting that in every community in the total population of older people there are people who fall into such categories. I also believe that they are often invisible to the rest of the community. No one else knows they are there until you begin searching them out. What we are saying is: let's make sure that when we do start a program these people are sought out and are involved.

Let me ask a question. Who's being served right now in our current senior citizen centers programs? Is it the people who show up automatically when you open the door of a project? Have we really gone out of our way to bring in the isolated and the withdrawn? You see, I have visited too many Title III projects and asked questions of the directors. Once, in the only senior center in the community, I asked, "How many people are you serving in your center?" The director replied, "An average of fifty-three each day." I asked a couple more questions. "Well, how many older people are there in this community?" He replied, "Well, about 3,500 or something like that." I said, "Where are the other older people?" And he said, "Oh, they don't want to participate in our program." I asked why not. "Well, they have no way of getting here." I asked, "Have you thought about emergency transportation service--that is, set up a transportation service for volunteers?" "No," he said, "that would be too difficult. I would have to arrange schedules for drivers and it's just too difficult. I just didn't bargain for that when I took the job."

I'm afraid that too many of our projects are seeking to serve only those who will show up wherever we open the door. We do not go out of our way and do the next job. What would happen in the nutrition program that we are about to administer if we just opened the door of 4000 nutrition projects in the country? I predict that they would be dramatically successful. Every table and space would be filled every day by somebody looking for a meal. I am not saying that's wrong, but I would ask a question. Are the people who show up those who need the meal and need the socialization that comes from a congregate meal, those who need the service the most? We are suggesting that we go out of our way, into the back rooms, and see to it that these people get escorted out and perhaps transported to a meals program.

In closing, we must remember that if we follow an approach in terms of special target groups, we will have some additional challenges such as--How are we going to determine such a need? How do we find such older people? How do we get such people to services? These are really some very,

very tough questions, and I won't try to answer them. I understand the very next session by Dr. Blenkner is going to answer some of these questions.

Here's a new challenge for us, and I think our lives in the next couple of months are going to be full of such challenges. I think we have to come down and put real emphasis on target groups in the very beginning of the program, lest the program follow the course of action of our earlier Title III programs. We open a lot of projects, we do a lot of good, but we have to ask a very serious question. "Are we doing good for those people who need it the most?" I think we cannot enter this new strategy or any new program unless we make certain we can assure ourselves that there are no unknown Mrs. Joneses in the community, no unknown Mr. Smiths, who die without anyone's knowing it and are found by a policeman. We have to make certain that people who need services the most are taken out of their homes and into the community, linked again with the community, and linked with the services they need when they need them.

THE GOAL AND OBJECTIVE

Stanley Brody

I guess I ought to tell a soul story at this time, after listening to Charlie Wells a little earlier. Among the Eastern European Jews in the 19th century, the way of looking for a rabbi was not too different from the way we do things today. They had an auditing committee, and sometimes the whole community formed the committee. They usually invited prospects to give the sermon for the week, and then they passed a judgment as to whether they were going to have a certain individual as their permanent rabbi. Two prospects came to this particular East European town at one time. One was a very young man, bright, very similar to the men surrounding Charlie Wells and company in Washington right now, and one was similar to some of us older folk who have been there before. They were put up at the same inn. The old man rehearsed his speech over in the evening because he was very anxious, and you can understand how some older people get about a job. The younger man proceeded to rehearse his, too. During the intervals, the older man listened and realized what a brilliant job the younger man was going to do. So he shut up and listened some more. The next morning they both got up and went to the synagogue, and the older man said very grandly that he would defer to the younger chap and let him go on first. So the younger man got up and gave his oration. When he sat down, the old rabbi then got up and said, "You know, I've never really heard such a brilliant speech as that. In fact, it was so brilliant that it engraved itself on my memory, word for word." Therefore, he proceeded to give the same speech, word for word. Now, Charlie, looking at you as the younger man, I almost have to feel that I might have to say some of the same things.

In listening to Carl Eisdorfer, Frank Nicholson, Charlie Wells, and Ellen Winston, I can only think, "My God, what happens if we win?" I realize--and I hope that you, too, are beginning to understand--that we have won, at least the first round. My anxiety is accentuated by the fact that I've been here before. We won before, at least the first round. It's very rare that I have a second chance. It reminds me a little bit of the vaults in the New Orleans cemetary which have long air pipes over each of the departed, just in case. I feel like shouting through that vent that we still have a chance, that we have been given another life. Our first chance was about ten years ago--Ellen Winston can tell you about that--in 1962, when the public assistance titles gave us what we had been asking for, open-ended social services. We had meetings just like this one. As a matter of fact, I have the feeling of **deja vu.** I don't know whether others have the same feeling today, but I almost feel that I've been at this meeting before. But either we didn't listen or we didn't understand and lacked the courage and commitment that was needed. We didn't understand when Dr. Winston said, like Willie Loman's wife, in **Death of a Salesman,** "Attention must be paid." It's ten years later, and here we are again.

Early in this administration, Secretary of HEW Bob Finch took the position that the first priority for this administration is children. As a matter of fact, he took it very prominently in the **New York Times.** The biggest bang for the buck, according to those cost-benefit analysis fellows, was that of putting your buck in children. It happened that we were meeting in Washington at the International Gerontological meeting, and some of us were working with the President's Committee on Social Goals, so we had an end to the means. We got together a sample of our leadership from all the gerontological skills and disciplines--economics,

medicine, psychology, political science, social work, biomedicine--and we descended upon the White House. Don Kent saved the day by pointing out to these PPBS fellows and cost-benefit analysis fellows that you can't do anything politically without caring for the aged because of their voting. The aged are involved with the next generation. From that effort and Don Kent's great statement, backed by hard, tough research, many other new strategies were evolved by this administration; and perhaps for the wrong reason we're getting the right things.

The role that we've been assigned is an initial role in a much larger picture. Whether we like it or not--and I don't know what better terminology to use--this is where we are. Let me share with you, in the best Drew Pearson-Jack Anderson tradition, an in-house description of the new proposed Allied Services Act of 1972. This is their (the administration's) language and Richardson's point of view:

> The proposal of the Allied Services Act of 1972 is intended to encourage states and localities to coordinate the provision of human services to individuals and families which will assist them in obtaining the greatest degree of personal independence and economic self-sufficiency that may be feasible, or which will prevent individuals and families from becoming increasingly dependent for both financial support and personal care from public and private programs.

The Act defines various key terms. The "coordinated provision of services," for instance, means (1) services needed to remove barriers to self care, independent living, and self support, provided in such a way as to facilitate access to a use of its services, (2) improving the effectiveness of the services, and, (3) using service resources more efficiently and with minimum duplication. Likewise, it includes many services provided to maintain or achieve personal and economic independence. Since I am talking only about goals and objectives we can stop there. The proposals, as far as this program is concerned, are tied into this larger strategy.

Now let me read to you from HR12017, from the Older Americans Act Amendments of 1972:

> (1) Make available comprehensive programs which include a full range of health, education and social services to our older citizens in need; (2) give full and special consideration to citizens with special needs in planning such programs and, pending the availability of such programs for all citizens, to always give priority to the elderly with the greatest economic and social need; (3) provide comprehensive programs which will deliver a full range of essential services to our older citizens, and, where applicable, also furnish meaningful employment opportunities to many individuals including older persons, young persons and volunteers of the community; (4) insure that the planning and operation of such programs will be undertaken as a partnership of community, state and local governments, with appropriate assistance from the Federal government.

To recapitulate: There is an overall Richardson-HEW strategy for a new human service delivery system. I think, in reaction of the state executives particularly, that you're in to a different thing here with planning. In the short meeting we had with the executives in discussing this program, unfortunately, one of the major problems that were raised was: how are we going to pay for travel out of state? Perhaps when they get to weightier situations they may understand that we are talking about **new planning.** We're not talking about Title III, Mickey Mouse stuff.

We are talking about long-range plans for the aged that are goal-oriented, that are not rhetorical, that are mechanisms, that are process-oriented, that will carry feedback on a continuous basis, that will have participation from older people as well as other providers, etc. So we're talking about objectives which will accomplish these goals, development of new state plans for the aged. Nothing that has come before has any relevance. We're not talking about a show and tell, but about keys to evaluations and objectives, accountability. In terms of those objectives we talk about dynamic planning, about process and feedback.

Secondly, we're saying that these plans will be locally oriented, that the state will be divided up by its governor into regions, preferably according to existing arrangements. Of course, as we said, forty states already have this. So we are talking about existing regions which have some validity and a history of acceptance.

Locally within these regions we are talking about a concept--if I may borrow from the experimental health design--which talks about the importance of the involvement of the four P's. The first P is public. The public we are talking about is the consumer, the aged person, the older adult. The second P we are talking about is the provider, and that's the agencies and individuals in this room. The third P is political, and that again means some of us. We are talking about both elected political and administrative political. The fourth P is the payer. That could be government as well as the insurance companies, Blue Cross and Blue Shield and private health insurance companies. These four P's are going to meet together in process and development in long-range plans in local programs within these regions, and in area-wide plans. They are going to establish a priority among these programs in response to documented needs. We are going to look at state plans for this full participation data base, clearly stated goals, objectives, and priorities. The time is such that the sign-off will probably come at the regional level, so the regional people are going to be even more important to you than they are now. They are going to be looking for full participation, and they are going to be looking for clearly stated goals and objectives and priorities.

We are going to have to integrate services at the delivery point. If you think that some day in this country we are going to have a single block of money, under a single agency, for general use, forget about it. This country is a pluralistic country. You can see it in the elections now. We are always going to be a pluralistic society, and this fact is going to reflect itself in legislation. Legislation is going to be compartmentalized and oriented to pressure groups, and we are always going to have multiple programs. The question really is: "How do you integrate?" Well, one of the ways that were suggested is advocacy. That's what this program is about as far as you are concerned. Two hundred million dollars isn't going to do it. It may do for a start, and hopefully you will generate enough constituency and enough of a track record so that you will have confidence in yourself and so that they will support you when you ask for more money. But in this first year, you are going to have $200 million to support your advocacy, and you are going to be asked to develop program areas which lie outside the Administration on Aging and outside the administrative control of the state unit (for example: housing, agriculture, transportation, mental health, public assistance).

Mental Health is a good one. Taking a good look at the back report in terms of what's happening in mental health and the enormous expenditures in West Philadelphia, where I come from, I find a program for a very small part of the city which is well on its way toward three million dollars in funding. Yet looking at it you find that very few aged are being served. Psychiatrists, like the rest of us, don't like to serve old people. Here is chance for advocacy, a chance to see if you can climb aboard that money and start to muscle it. One of the ways, of course, is by using the one fee, the public fee, the aged themselves, to enforce your advocacy. There are 126 federal programs which provide services to the aged.

A local program will be one in which all four P's participate with maximized integration of all voluntary and public funds within the framework of long-range planning, focused on solving priority-identified, specific, documented problems of the older adult with the greatest economic and social need. We have to have a documentation in advance to undertake the program. Again, the focus, helping you identify your priority, is with the older adults with the greatest economic and social needs. The state plans will reflect these local programs, hopefully integrated into some thematic quality that is unique for that state.

These state plans again are going to be dynamic, process-oriented, in terms of goal setting, in terms of evaluation, in terms of feedback, no show and tell, no dumb reports, no nonsense. There will be no more "so and so made fourteen visits to a

Senior Citizen Center or opened twenty-three and one-half senior citizen centers and had 24,323 visits." We are not talking in those terms, because we don't want to waste another bundle. We have been evaluating children and youth programs by counting the number of times children saw doctors and nurses, and that doesn't mean a thing.

If I sound angry about it, it's because I have a lifetime of anger and frustration behind me. People like ourselves have been thoroughly and completely unaccountable to the community and to Congress and to our legislators. We come to be against our legislators as I have and as I am sure some of you have. They ask you what you have done, and you tell them you've made 24,323 visits. They say, "What does that mean?" You say, "We did good." You can't do that any longer; it will not be tolerated. This program is going to give you the framework in which to work without the possibility. This is a new ballgame. For the first year, it will be well funded. The only reason it's well funded within the first year is because you will have a terrible time trying to get that money out. As it is, you don't spend all the Title III money that you show. So, for the first year at least you will have enough money. After that, though, there's not nearly enough money for the eventual cost of the program. The discretionary money--and a lot of it will be discretionary--will go to states that respond quickly in trying to explain their programs to the executives in Washington. They put it on the line. The fastest gets the mostest. That may not be fair, but it's effective. It is part of the historical development from categoric to comprehensive approaches to specific problems of documented high priority, and it's a second chance. We've won--so far. The aged isolated in the second-floor rear rooms who are under-nourished, confused, and vulnerable are saying to all of us, "Be our advocates; attention must be paid." I say to you, as Chairman Mao and President Nixon both said, "Seize the moment."

STRATEGIES TO IDENTIFY AND SERVE THE TARGET GROUPS

Margaret Blenkner

We have talked about target groups, strategies, attacks, shock troops, and so on; so let me make an attack. If we are talking about serving older people, the first decision we have to make is whether or not we are trying to do something for the old people or something for ourselves. We are going to have to stop talking about what old people need and pay a bit of attention to what they want. Most of us in this room are professionals, and if we are honest--and sometimes that's hard--we know that when we talk about planning programs for people we each arrive at a program that says what these people need is what I can do. We all work it out so that what the persons needs, what the so-called target group needs, is what we can do. We do it over and over and over again. And that's about what we are doing in this meeting.

The second thing we have to make up our minds to, if we are really going to get down to business about strategies of helping older people and so on, is that we are going to have to spend as much money to keep people out of institutions as we've been spending to put them in. Most of our professional resources--and the more highly professionalized they are the more this is true--in the United States are geared toward helping old people get in institutions or taking care of them once they get there. We simply have to face the fact that if we are going to keep people out of institutions in a way that they want to be kept out of institutions, we are going to have to spend some money. I'm not just talking about the federal government; I'm talking about voluntary agencies. Look at the vast amount of money church groups spend on aging. Where is their money invested? In bricks and mortar, in homes for the aged, in retirement colonies, in this, that, and the other. Once you get stuck with bricks and mortar, then you spend your time trying to fill institutions, and your program becomes one in which you want to get people into institutions instead of out. I'm sorry, but it's true. Look at where our most highly developed professional resources are. They are in institutions. They are not relating to people in the community.

A third thing--this, I think, is one time where I really am going to talk about strategy. I think it is a mistake in strategy to concentrate your major resources, practically all of your resources, on the persons who are most likely to end up in institutions. You had better concentrate your resources on those people who have some chances of staying out. We do this over and over and over again; we plan or provide services for people who are almost already beyond help. I'm not saying those people do not need help, but you should not put all your resources in that basket. If you are going to make an attack on cancer, you do not put all your resources in terminal cases. But this, in effect, is what we tend to do. I think it is a bad mistake in strategy for more than one reason. One reason, of course, is that it will make you look bad regardless of what you do, because you can't win.

Another reason is that you want people involved in your program as consumers who have some energy, some strength, and some clout left, because you want their support. Persons who are in the most desperate shape, physically, mentally, emotionally, are not the ones who can do that. We can all feel good about taking care of them, but they are not going to have the kind of effect you need. As a strategy of getting things done, you are going to have to have a consumer group in back of you to fight for your program. So, you want a sizable group of the people you serve still able to fight.

Also, just as a principle of public health, if you are going to meet a problem or have any real impact on it, you have to put a very heavy input of your resources into the problem at a level where what you have to offer has some promise of not only alleviating a very difficult situation but also preventing further deterioration.

Another point I want to make about thinking about strategies in relation to services to the aging is that we have to make up our mind that aging is a chronic affair. It is not going to be treated, rehabilitated, or exercised away. People get old and older, and yet in this country the major program that we have created in the last ten years that affects the greatest number of older people in terms of making services available to them is Medicare. Medicare has an acute care strategy, which is absolutely the wrong strategy for meeting the needs of the aged. Yes, mental health is infected with it now, too. Everybody is talking about crisis treatment, crisis therapy, crisis intervention. Crisis treatment is not the way to meet chronic problems, and yet we persist in doing it that way.

I wanted to say a few words about what seems to have been the major subject of conversation in this meeting--this $200 million that is going to be available for planning. Steve, who is a friend of mine, made some reference to Micky Mouse Title III projects, and I admit to having made such references myself in the past. But face it! That $200 million may be spent for the greatest proliferation of Mickey Mouse planning you ever saw in your life, unless something is done about it. We are still operating on the assumption--and it's about time somebody said so in this meeting--that planning will somehow or other make non-existent services exist, that creation of information and referral programs gives you something to refer to. They do not. No amount of community organization will make up for non-existent services, and it is a lie to say the services exist when they do not. In fact, I'm beginning to wonder about all this talk about $200 million, which is not very much money when you divide it up among fifty states. Do you realize that? You know the real money is in Title XVI of the Social Security Act, which is still open-ended. I'm beginning to wonder if all the talk about all the great things that are going to be done with that $200 million in planning money is a way of distracting us from the fact that we need to keep on fighting to keep Title XVI open-ended. I'm making that as a serious remark. In fact, it seems to me that the real strategy we have listened to this afternoon is how to make $200 million sound like $2 billion.

THE IMPACT OF SCIENTIFIC ADVANCES ON INDEPENDENT LIVING

Carl Eisdorfer

Not everybody is going to fall apart the day after he quits working. As a matter of fact, the evidence shows something quite contrary for a large segment of the American working public.

If you break society up, using the old socio-economic bit of high, middle, and low, "low" is usually blue collar or productive assembly kind of work. It may not be low economically, but it's low in socio-economic status breakdown. It turns out that three studies I know indicate that retired workers get better after retirement, for at least the year or so following retirement. For the blue-collar workers, health gets better after retirement. The reason for this is that many people are hanging on till age sixty-five in order to retire at slightly higher Social Security. So they're working when they are sick and really don't want to work. If they were able to retire at 62 at the higher base, they probably would have retired at 62 or 63. There are many arguments for a flexible retirement age. Some people would be happy to get out of the labor force early, particularly people in production.

Consider the high socio-economic group. People in this group seem, just before or immediately after retirement, to show signs of emotional upset. After about six months, though, these people seem to make a new and pretty effective adjustment. They find new activities to replace their work activities. They find retirement activities, volunteer activities, travel, and so on. This group has an advantage in that these are the people who are manuevering in communities anyway. They are the ones who have been rich enough, strong enough, powerful enough, well-fed and healthy enough to know how a community runs. In fact, in many cases they have run it. Even if they stop running the factory or the plant or the business, they find that the same kinds of skills are effective in the new community, and they make a good adaptation. Some have six months of problems; some don't even have that. They take a trip, work at their problems away from home, come back, and make the readjustment. This has also been confirmed in a couple of studies.

If there is a retirement crisis per se, it's at the middle-level group. Here the evidence is elusive at best. For example, you find it most clearly in the military, where people retire at middle officer's rank after twenty years because they didn't make bird colonel. They have another problem, in effect, in that this is a forced retirement, not an automatic retirement. If they had been promoted they could have been kept on for a longer period. One of the things you know about these people as well as a lot of people who expected to get higher up in their own job--and these are typically white collar semi-professionals--is that they retire with a sense of failure. Your blue-collar worker doesn't retire with a sense of failure. He has already locked into his job and has not been particularly interested in the product he was making. His interest seems to be more with his union than with his employer. The middle income individual, on the other hand, typically has the responsibility of signing his name to something. If you are identified with something, if you put your signature on a piece of paper, it belongs to you. I think this is very important.

Now you have to decide whether you wanted to be head of the agency or not. If you never expected to be head, then there is no great problem. If you wanted to be the head, at some point you have to work that desire out of your system, for retirement signals the end of a possibility.

Now I've given you the first year following retirement. If you look about two or three years later, you have another set of problems. The middle income person does have continuing problems, and the low income person now begins to have problems, problems related to money. This relates to another study that was done in the Pacific Northwest, Oregon and Washington, using several thousand upper-middle income technicians. These are bright people, high school and college graduates by and large. This goes back four years ago to an AoA study in the aerospace industry. The intriguing things were, first, that nobody seemed to prepare for retirement and, second, that when they asked people how much money they were making they got a reasonable dollar figure. When they asked them whether this was enough to support them, though, about 85 percent of them said "no." They needed much more money to be able to live effectively. These were people fifty-five to sixty-two who were from three to ten years away from retirement, who were saying that they didn't have enough money to make ends meet. Then they asked these people whether they would have enough money in retirement, and about 85–90 percent said "yes," they thought they would have enough money in retirement. These workers who said they would have enough money were going to get a reduction in income of roughly 55 percent. Let me explain what I just said. A man who's making a salary, whatever it is, and saying he can't make ends meet but that when he retires at a 55 percent reduction he will be able to manage. I think we need a saner approach to the whole business of money handling.

I bring this up to show that bright people are obviously using some form of what the psychiatrist likes to call "denial," in this case denial of reality. When people deny reality, it's not a simple matter of telling them that they are denying reality, because these people are bright enough to know they get a reduction in income. They all know it's a fact. We're dealing with an emotional issue, and it requires a much more subtle way of handling the problem. I have repeatedly suggested, for example, that retirement planning has to start in the early forties, not in the fifties, because by the time you get into the late fifties, when most people start worrying about retirement, it's so traumatic that it begins to look too frightening when you hear the data––and you turn it off.

People in their forties aren't interested particularly, but they can be made interested. I think it's to the advantage of all of us to begin to think about, if not other people's retirement, then our own personal retirement sometime pretty soon. I think also it implies something about the nature of people working in the field of aging. We have to broaden our mandate. You can't wait until a person is sixty-five before you worry about aging. We will talk about that in a minute. The great advances in health, keeping people alive, have not been in curative medicine. They have been in public health. It's the prevention of illness that really counts, and I am talking about the disabilities in aging. So I think we need to broaden our mandate. I think we need to sell this argument. Any of you working in the field of aging should see yourself as beginning to work with people at the age of forty.

Let's talk about health and its importance to you. If we are talking about alternatives to institutional care, it turns out that physical health may be one of the most important areas we can worry about. Most of you ought to know about the data coming out of the Langley Porter Institute in San Francisco, where essentially they set up a screening service to look at roughly 600 people a year in the San Francisco General Hospital, people who would have been slated for institutionalization. The study was done very simply. They dealt with roughly 600 people referred to San Francisco General who were above age 65, who were first psychiatric admissions, and who were referred because that hospital was the intake center for the state hospitals. They began the study for a couple of reasons: (1) because they are bright and sensitive people, and (2) because the state began to make noises like it was going to close down admissions to state hospitals. So they had to take a good look at what was going on. They brought in a psychiatrist, an internist, a social worker, a psychologist, some nursing help; and they decided that all patients who come into this thing for a psychiatric work-up would get a full-scale physical and social work-up

at the same time, and the results were nothing short of incredible.

They found that three-quarters of the people who were referred into this system had an acute, undiagnosed, untreated physical illness. Within two years, using alternate placement, social work, and medical help, they were putting only two people a year into the state hospitals. That's a fact: from six hundred to two. State hospitals were cooperating because they could raise their admissions standard.

During that same period, about one hundred people wound up in nursing homes in the community. What they demonstrated, then, was that with a combination of health and social service they could in fact divert the vast majority of people from state hospitalization. Those data are there, and that's been going on, by the way, for about ten years. It's hardly a new and exciting project, but very few people know about it.

I'll raise another question, and then I would like to get some feedback in terms of how we can make these kinds of data available. I think they are profoundly important data. I did a study in a state hospital in North Carolina which I never published. All I did, very simply, was to pick up thirty serial admissions in one of our regional state hospitals and discover some absolutely incredible things, things which really were indictments against the medical community. I've said this repeatedly to the medical community. Six people were sent in in one variety or another of coma where the coma was because of medical and nursing care in hospitals. They come on weekends, by the way, because that's when people like to take a day off; and they don't want to be bothered with having a sick patient in the hospital. If the patient is sixty, or seventy, or seventy-five, it's just easier to make a referral to a hospital, particularly if the patient is dehydrated, as were four of these patients, who had started to hallucinate. Hallucination is not an uncommon phenomenon in old people when they get ill.

It turned out that these people were not psychotic, however, but now were in a state hospital and couldn't get out. The state hospitals wanted them out, but there were no resources. It's always incredible to me how you have a pie, take out a slice, then decide you don't want it, and try to put it back--only to discover there's a whole pie there. You know, the older person has a role in the community, then he's taken out of the community, and suddenly--zap!--his world closes up and there is no place for him. That's in fact one of the things we have to worry about.

The way social services must operate in this arena may vary from state to state, but one of the things that's compelling is that you really have to operate in some kind of collaboration with the health resources available. Straight admissions from any physician to a state hospital must be subverted. I say this with my AMA and my American Psychiatric Association cards neatly tucked into my wallet. The medical community really has not been alert to the needs of the patient. So you have another role, which is an interpretive role; and that's really a very important one. It seems to me one of the key variables in keeping people out of hospitals. It is also true that families probably do not dump patients. Elaine Brody says unequivocally that families are very upset about having to dump their folks. They have to work on it long and hard, and as often as not the big problem is that they wait too long.

This leads me to the next general notion that we need to look at, the whole business of who gets hospitalized. The aged psychiatric patient has received a lot more attention than the aged nursing home patient until very recently, because of the stigma of psychiatry and because the National Institute for Mental Health has given very little to aging. Some of the people in psychiatry have looked at this problem. I think you ought to know, by the way, that up until a couple of years ago we were delivering to the state hospitals about a third of their intakes in the form of first-admission geriatric patients. Putting it in a different way, about a third of all state hospital first admissions were geriatric first admissions. On an out-patient basis, 2 percent of all out-patient mental health services throughout the country have been delivered to the aged mentally ill. So that's another area for work. We have to get to the community mental health community because,

whatever they are doing, they aren't attacking one of the prime reasons for getting into state hospitals, namely geriatric illness.

It is not clear, incidentally, that all of the people going into state hospitals don't need it, because just like everybody else they believe the stereotypes, and they act accordingly. State hospital patients are very adaptive. They are supposed to be crazy, so they act crazy. They are just like you. You're supposed to act like a professional, so you do--or try to. You may think I'm being facetious, but some superb studies have demonstrated that expectancy is the best predictor of what a patient will do. It has nothing to do with the state of the patient; it has to do with the state of the staff.

Let's talk about some research in this context, since this was an important piece of work. Lowenthal presented us with data, and there are a couple of books now--**Lives in Distress, Mental Health in San Francisco.** I think they really need to be understood by the social service community. First of all, what Marjorie has demonstrated is that one of the most important protectors of the aged person is what she calls the confidant. The confidant is the presence in the community of a person, an individual, with whom the aged person can talk. All other things being equal, it's typically the eldest daughter of a family. The roles of the confidant seem to be established and are very important. Rich and middle class people seem to establish them more than poorer people. Men seem to have less effectiveness at establishing this confidant relationship than do women. A woman takes a friend, very often a duaghter, but maybe an older woman. A widow, for example, may turn to another widow. She will be somebody to talk with, someone to rely on, someone she can reach on the phone, someone who is relatively near by. Let me mention that a lot of older people do not have somebody nearby whom they can rely upon. One of the reasons that they don't is because of the feeling that they are imposing. I'm trying to let you know that in your work in the community you can typically find somebody and help foster a confidant relationship. This is a crucial element in maintaining people in the community.

The people who wind up in state hospitals--and Lowenthal showed it in the Michigan study--tend to be the aloners--not just the **loners,** but the **aloners.** In fact, Gottesman found that this was so dramatic that he almost aimed at making the state hospital play an important role in checking up on them, because these people were alone in the community, had no one to care for them, to look out for them. It's interesting that Ruth Bennett has found a very similar phenomenon in New York, where again many people are literally alone. Here the role of social services in providing some kind of personal contact is very important.

Lowenthal also shows, in her many years of long study, something that somehow puts us on the horns of dilemma; and I will let you think about it. She demonstrates fairly effectively that the aged psychiatric patient tends to have symptoms for a long time before he gets service. That is to say that in her case patients seemed to have symptoms that dated back at least six months or as long as five years. Many people had been showing psychiatric symptomatology for a long time, but nobody bothered hospitalizing them until they got sick physically. Then, since there was no one around to care for them, they started hallucinating; and they had the psychiatric symptomatology which made it seem like a good idea to hospitalize them. They were now eligible, eligible by virtue of having disease. The interesting thing is that they had the same psychiatric disease while they were living in the community, but the physical disease triggered off the admission. This is what I've been trying to tell you. It's a very important concept. You can't ignore physicians, even though they are tough people to work with. Certainly we can't ignore health, and I'm not sure we can ignore physicians any more.

Another aspect of this situation is that psychiatric help was turned off by a lot of these people and by their families. So now we have a very interesting dilemma. One of the great pushes in community mental health has been the acceptance of deviance in the community. You have to appreciate the fact that not everybody should be locked up. Every time somebody does a little

something aberrant, you don't run and incarcerate him or institutionalize him. On the one hand, you have the notion of acceptance of deviance. On the other, you have this notion of people who are showing deviance and increasing psychiatric symptomatology for one to five years. Nobody is going in there to help them. One of the things that needs to be done, it seems to me, is to educate people in the social service community and begin to deliver a new kind of help--help in trying to get early psychiatric help and intervention on an out-patient basis for a lot of patients. Often by the time they come into the hospital you are dealing with somebody who has multiple systems disease. Then you've got all kinds of problems, because even if you divert them from the state hospitals, they wind up becoming long-term nursing home patients, which leads me to the other hassle.

We use the word "community" in very elusive terms. Only recently we have begun to figure out that a nursing home is no more a community than a state hospital. The data also show, very conclusively, I am afraid, that geriatric mentally ill patients do better in state hospitals than they do in nursing homes. The long-term studies of Simon and Epstein show, by virtually all criteria--walking, talking, bathing, the amount of flexibility that people have, you name it--that long-term patient care results in a better, more adaptive, person in a state hospital than in a nursing home. This study was done in twenty-six nursing homes in the Bay area, and they were by and large pretty good nursing homes. Patients were really deteriorating there at a faster rate than in the state hospitals. There may be some extra reason for this. In California nursing homes get more money for keeping the patient in bed than for having him walk around. That's not unique to California, by the way. That's a classic example of the psychosis of social service management. Everything you know about reinforcement theory says they ought to pay to make people better, but we pay to keep people in bed. If you get an extra two to four dollars a day to keep people in bed and there's no bonus for getting them out of bed, where do you think the nursing home manager is going to keep his patient? I realize that there are problems the other way around, that it **should** cost more to keep patients in bed. You can almost make it cost less, though, if everybody is getting the same care in bed. Then it might in fact be cheaper to keep people in bed than to have them wander around the halls. Some of you are in positions to do something about this. It's a matter of thinking very carefully about the effects of fiscal policy.

I have to bring up the beer and wine studies of Kastenbaum. These studies happened to be done within the state hospital, but some of the issues raised there should apply to the care of people in the community. They are a variation of the theme. We are talking about the expectancy and the role relationships, and I talked about advocacy the other night. Kastenbaum became the research director of the Cushing State Hospital, which is in Massachusetts and is the hospital primarily devoted to geriatric psychiatric patients. If you have been to any state hospitals lately and looked at the way geriatric psychiatric patients are cared for, you know about how the Cushing State Hospital works. It's no better, no worse. Bob Kastenbaum was concerned about the models of care. We all know about the medical model, and I think it's a bad term because it means too many different things. But basically the notion is that the aged mentally ill patient is somehow sick and is a patient, and all patients are targets. That's why I was coming on so heavy the other night. They were supposed to be crazy sick, so they were some kind of crazy targets--the helpless, hopeless syndrome. So he was looking for a way to break out of this deadlock, and he came up with an idea.

A lot of money is spent in tranquilizers. The use of pharmacologic straight jackets for geriatric patients is one of the great scandals of America today. A couple of years ago 250 million prescriptions for tranquilizers and psychotropic drugs were written by non-psychiatrists--250 million. It's not clear how many are written on geriatric patients, but over and over again you run into this business of finding people who are totally wiped out. We don't use straight jackets anymore; we are using chemicals now. In this situation, Bob came up with a notion, and he sold it to the physician on the basis of alcohol's being a good tranquilizer. It is, in fact, and there's been some very good research data on that. His notion was to

have a cocktail hour and serve wine, which he got free, to the patients. He sold it because it was a tranquilizer.

He was really trying to sell a different principle, though. The principle simply is that patients don't have cocktails, patients don't drink wine; and this sets up a conflicting social model. He was saying that the patients will get a very different message from getting wine than from getting pills. Some of you are sort of smiling at me, thinking that's kind of wild. Well, it is wild because it's disonant, because it's not supposed to be what happens to patients; but that is exactly why he wanted it. He in fact did set up a system where they had a wine cart coming into the ward at 4:00. The results of this study were nothing short of phenomenal. The first thing he began to notice was that the patients got better oriented. He noticed that people who had been disoriented as to time, place, and person suddenly knew what time it was. Sounds funny, right? Do any of you know how important that is and how in state hospitals there are no clocks and no calendars? If you were there for seventy-two hours you probably wouldn't know what day it was. But if a patient doesn't know, we mark it on his chart; and that's an excuse to keep him in the hospital for another month. Under this program, though, patients who never talked began to talk, patients who couldn't shave themselves began to shave themselves, patients changed for cocktails. The staff couldn't believe what was happening. Patient management changed, and they saved incredible amounts of money on drug bills.

So they pushed it, and they went on to do the beer study. The wine study was successful, but the state wouldn't pay for wine, and the program had to be dropped when they ran out of free wine. It wasn't dropped because it was a failure; it was dropped because no one was ready to pay, even though it would be cheaper and more effective than any of the other techniques they were using. So they went on to the beer study. They got free beer from Boston. This time, though, they went to a ward which was called Death Valley. Patients went to that ward when they got deathly sick, and they were lying there in various states of near-death. They took the beer cart to Death Valley, and for the first time in the history of Death Valley they began to get returns. About 30 percent of the patients who were on this ward began to go back to their old wards. They didn't equate (a) being a patient and (b) the ambience of a ward change. The attendants in that ward had been studied and it was found that they never spent any extra time on that ward. They ate off the ward, took their coffee breaks off the ward, and were very willing to run messages for anybody. Nobody in the working group wanted to stay on that ward. After the beer started--and the attendants weren't getting any, by the way--the amount of time that the attendants stayed with the patients went up by an incredible amount.

The beer experiment was stopped in a very bizarre way, though. The daughter of one of the patients was on the ward when the cart came through, and the ward got very noisy. You know, the patients got very agitated and excited because the beer was coming. They were really pleased. They got only one glass of beer, by the way. She complained to the governor and the state hospital and all sort of people, saying it wasn't appropriate to bring beer to these sick people. So it stopped.

I think this makes a great point. That point is that you get what you expect. If you victimize--and I'm using that word in a very special sense, but you can interpret it however you want--if you make somebody a victim, he becomes a permanent victim and becomes more and more and more dependent. If you make him a resource and a partner in his own care, he will respond accordingly. That point needs to be driven home again and again. It is not easy, because you see these people as being without resources.

I'll have to say something about health now just to point out that I know something about it. Maybe the following is appropriate. In the literature today, the curve for adult intelligence is called the bow-shaped curve. It goes up to a peak, then down slowly. It used to peak at about age sixteen, but the guys who developed the intelligence test got a little older so it peaked at twenty-three, twenty-four, or twenty-five. This very classic curve you see describing the aging process goes down from this point. Everybody knew that's what

happens when you get old. You get brighter up to one point, and then you begin to lose marbles slowly but inexorably. At some point you have no marbles left; you are just lying there like a demarbleized jellyfish, waiting for something to happen. It would be nice if this kind of information were usable because there's so much of it.

We now know that those data are wrong, though. Those data are wrong because they were done on a cross-sectional basis. What nobody bothered to think about was the fact that the average twenty year old has about nine and a half years of education, education that was roughly a nine-and-a-half-month-a-year proposition, whereas the average seventy year old has about four years of education of four months a year. Our attempts to compare intelligence have been sheer nonsense, as we've been comparing education. Nobody in his right mind would say that sixteen months of education is going to wind up having the same effect as eighty-one months of education. So the cross-sectional studies have problems. Longitudinal studies take time and they're expensive, but they're finally beginning to bear fruit.

Research in aging, in fact, is very, very new. The Duke study is one of two or three of the oldest in the country, and ours dates back only to about 1955. Taking a group of people between sixty and seventy and following them for ten years and then winding up ten years later with a group of people between seventy and eighty, we found that there was no intellectual decline in that group as a whole, whether intelligence was high, middle, or low. This is contrary to all the cross-sectional professional studies in this regard, but other people have found the same thing. So the concept of individual deterioration as a necessary part of aging has, I think, been knocked into a cocked hat. The evidence is so compelling now that the task force on aging of the American Psychological Association has said there is no evidence for intellectual decline at least until age seventy-six.

We do know from reality that older people do have more trouble learning. This raises a very compelling problem. Why? If the pure psychology types are saying people aren't declining--though behaviorally they are changing--then we have to ask why. I think you know the answers. Look at the distance from education between a sixty-five, a forty-five, and a twenty-five year old? What about the concepts of life-time education? I give you gratis the Eisdorfer self-destruct diploma plan. I think that all the diplomas on your wall ought to dissolve five years after you're awarded them. Then it's time to go back and get more education. It's very clear that the muscle between your ears deteriorates at a rate faster than the muscles in your arms and legs.

That's something we need to do in the community. We need to develop patterns of lifetime learning. That's no joke. Presently we are actively promoting deterioration. I think we have programmed the deterioration of older Americans, and that is a violent sin of omission.

The studies we did also proved that where people are physically ill (and here blood pressure is implicated) deterioration does occur. People with hypertension will deteriorate at a much faster rate than normal. Here's another thing we can do. We can make sure that the people we work with not only have health exams but also have some kind of on-going care. Where hypertension exists but where drugs are supplied to make subjects normal-tensive people don't decline. The older people we were working with, unfortunately, didn't have the resources, and they weren't getting the kind of drugs that would maintain their blood pressure, so I couldn't show this. We were not allowed by the nature of our support to provide any kind of medication.

I could go on to great lengths, but I think I've made the point. We're not just being nice guys. Expectancies, health care, the delivery of services to the community, the availability of a confidant, some kind of contact, changing the attitude and posture of the aged individual to be a partner rather than a target: all are very, very necessary components in maintaining people for independent living outside an institution.

Let me give you another bit of research data before I quit. It's worth repeating. Until this point we have had an increasing low-level problem in the field of aging. In the last sixty to seventy years,

approximately, the population of the U.S. has gone up about two and one-half times. The population of people over sixty-five has gone up approximately seven times. It is true, however, that the longevity of individuals from about age sixteen, the predicted life span of individuals aged sixteen, has not changed dramatically in the last fifty years. We are getting more older Americans because we're keeping more kids alive--not because we're extending life.

The prediction of 40 million older Americans by the turn of the century is based on the current projections, but now we've got a problem. President Nixon has launched a very impressive 400-million-dollar campaign to wipe out cancer. It happened last year, and this year he's talking about another one to wipe out cardiovascular illness. Those are diseases not of childhood but of advanced years. We now have to talk about a different set of problems. What about the prolongation of life? Why?

SERVICES TO MAINTAIN OLDER PEOPLE IN THEIR HOMES

William G. Bell

A groundswell has developed in the United States on the urgency of developing feasible service alternatives to institutionalization for older people seeking to retain a measure of independence at home (2, 5, 7, 9, 10, 11, 12, 14). An escalating social concern to help older people remain in their own homes transcends programs for all elderly, whether they be directed to the well or incapacitated. For elderly who are reasonably intact, accessibility of essential services in the community can perform a preventive function contributing to continued well being and social functioning. For elderly who may be impaired by reason of physical constraints on their capacity to function normally, there is need to develop additional options in the form of community based services and help resist the drift towards institutions. Action to enlarge choice in service delivery systems is presently a major goal of several national organizations and the federal administration (10, 11). Older people are highly susceptible to the impact of an industrial-urban milieu apparent in enforced separation from the labor force. Associated with the phenomenon of retirement are potential shifts in life style, reduced money income, potentially diminished physical and mental health, and changed marital status. Elderly persons, therefore, need to invoke a series of problem-solving resources, from an available range of alternatives in the effective environment, to maintain an acceptable level of independent living.

The primary focus of this presentation is on elderly requiring long-term personal care. The issue of supportive service to assist older people to remain at home cuts across all sectors of the aging population. A pronounced trend towards institutionalization of incapacitated older people suggests there is considerable merit in addressing specific service issues related to elderly requiring long-term care.

Nature and Scope of the Problem

Older people in their later years are particularly prone to the disabling effects of chronic illness which tends to bring in its wake the threat of functional impairment and major demands for sustained personal care. There are several ways functionally impaired elderly obtain needed care and assistance. A limited proportion (approximately 4 percent) are cared for in institutions; some living at home care for themselves; others are cared for at home by families and friends with the aid of intermittent community services. Among the range of formal health programs for elderly, priority use of public funds is in the direction of institutionally-oriented services channeled primarily through hospitals and nursing homes. As a consequence the major burden of care for dependent elderly tends to fall disproportionately on families providing help to elderly relatives in "one-bed hospitals" at home (4).

Within the substantial group of chronically ill elderly, Shanas has drawn attention to a

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particularly needful subgroup, labeled **functionally impaired.** These are individuals residing outside of institutions who require consistent help from others to cope with normal demands of daily living. Dependency on others is created when elderly become bedfast, housebound, or experience difficulty moving about or walking. Routine tasks such as getting out of bed, bathing, dressing, marketing, shopping, preparing a meal, or cleaning the home are performed either with extreme difficulty or only with the aid of another person. Based on a national study, reported in 1968, Shanas estimates 14 percent of the population aged 65 years and over were functionally impaired but still resident at home* (9). To sustain these diabled requires a range of coordinated supportive services delivered regularly to the home. In point of fact in most American communities integrated home care is either non-existent or inaccessible to medically disadvantaged elderly and their families (14).

Pressure for the development of additional options in the form of community-based home-delivered services in contrast to an overdependence on institutionally provided care has been given added momentum by a growing recognition of inequities in current health care policies and practices affecting older Americans. Compare an established, costly institutional network comprising congregate facilities, health professionals, specialists, and supporting personnel for some 4 percent of the elderly at home characterized as functionally impaired. For a substantial group, estimated at thrice the size of the institutional elderly, there is yet to be developed a stable integrated system of care approaching in scope the range of services provided through the institution. The net effect of present health care practice is to undermine the natural family system of the aging and drive some impaired elderly unnecessarily or prematurely into long-term institutions.

It is time the concept of long-term care ceased to be viewed as synonymous with long-term care **in institutions.** Granted the necessity of providing extended care under institutional auspices, more diverse approaches to impaired elderly are needed. There is considerable merit, therefore, in directing systematic attention to a reappraisal of current health care delivery methodology bringing into scrutiny functionally impaired elderly who tend to be ignored or underserved by present health care delivery systems.

Evidence from the 1970 U. S. Census suggests the number of elderly likely to require long-term personal care is on the rise. This claim is based on an observable relationship between functional impairment and the onset of old age, matched with consistent growth of the population 75 years of age and over. As Riley and Foner indicate, there is a close association between functional impairment and advanced years (8). Brotman points out the 75-plus age group is increasing at a steady rate with each succeeding decade. For example, in 1950, elderly aged seventy-five and over represented 31.4 percent of all elderly 65 years and above; in 1960, the proportion rose to 33.6 percent; and by 1970, 38 percent of the aging population were 75 years and over. Moreover, between 1960 and 1970 the aged group, 75 years and over, increased almost three times the size of the group aged 65 to 74, 37.1 percent compared to 13 percent (3). On the expectation these demographic trends are likely to be sustained in the current decade and given a demonstrable association between functional impairment and the later stages of life, it is logical to expect an increase in sheer numbers of elderly for whom long-term personal care will be necessary.

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* Based on a national population of 20 million elderly, approximately 3 million are estimated to be functionally impaired.

The Policy Issues

Consideration of optional models of health service systems for dependent elderly is given added weight from a brief review of policy issues related to the provision of long-term personal care. At least three salient issues are closely identified with considerations of alternate modes of health care delivery. These can be labeled the economic issue, the personal preference issue, and the family role issue.*

Economic Issue

This issue emanates from the realistic fiscal situation confronting policy makers at national and state levels. Efficient use of available limited public funds for long-term personal care of low income elderly, for example, requires that a choice be made either to continue present emphasis on institutionalization or to modify present patterns of service delivery. As an illustration, in reviewing recent public expenditures in Florida two concurrent but opposing trends came to light in facets of the state's Old Age Assistance (OAA) caseload. A steadily **increasing** OAA patient load in nursing home, supported by Medicaid funds, coincided with a steadily **decreasing** OAA caseload receiving direct assistance at home. Between 1966 and 1970 OAA patients in nursing homes rose from 5700 to about 8500 while in the same period the OAA direct assistance load dipped from 80,000 to 61,000 (2, p. 8).

In the absence of alternatives to institutionalization are some functionally disabled elderly forced prematurely into costly nursing homes? In one Florida county, professional nurses in nursing homes judged that 30 percent of Medicaid patients admitted in the period of one month could probably have postponed admission had basic care been readily available in the community at the time of admission (2, p. 28). Since nursing home care is expensive and will increasingly become more so it is vital to keep the nursing home population within bounds. It appears, however, that present policies may have just the opposite effect, since the present delivery system for long-term care tends to encourage institutionalization and therefore the use of high cost services.

With increasing numbers of older people in the United States and more elderly moving into the over-seventy-five age category, so closely associated with long-term disabilities, it becomes necessary to consider program alternatives likely to serve more people but at lower costs than at present.

Personal Preference Issue

A number of studies have suggested that older people reject the institutional solution to long-term care. For example, the Florida study cited earlier interviewed Medicaid patients newly admitted to licensed nursing homes in one county and a comparable group of Old Age Assistance recipients living at home to ascertain their preferences in living arrangements. Despite the foreknowledge of major disabilities, some 85 percent of both samples preferred to live at home, not in an institution (2, p. 23). Those out wanted to stay out. Many already in wanted out. It appears older people are content to settle for fewer health services delivered to the home in preference to extended care in nursing home facilities.

Older people have arrived, through intuitive means, at a position shared by many health professionals who question the effectiveness of institutions for therapeutic purposes. A strong thread of doubt underlies a growing disenchantment with sustained use of institutions for individuals requiring differential assistance or treatment over long periods of time.

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* The material in this section draws heavily from a study report prepared by the author (2).

Certain features of institutional environments when submitted to examination suggest the net effects of communal living for elderly may be detrimental rather than beneficial. Claims of administrative economies and efficient use of specialized staff and resources traditionally associated with institutional programs tend to be outweighed by rising capital and operating costs. Other negatives are linked to delivery systems oriented to institutional facilities. Evidence from a host of recent studies contends that institutionalized elderly suffer from depersonalization, deepening isolation and separation from normal society, loss of privacy, tacit forfeiture of civil rights, deprivation of intimate family relations, and the threat of higher mortality rates compared to elderly living outside of institutions (6).* As a consequence the desirability and effectiveness of long-term care channeled largely through the institution has come into question.

A prevailing image of institutional life as largely negative has brought in its wake a mounting demand not to eliminate institutions but to deinstitutionalize critical health services by making them more accessible, flexible, and designed with an eye towards elderly resident's at home requiring differential, perhaps more modest, forms of long-term care and assitance.

Family Role Issue

The practical evidence runs counter to the view so strongly held by some theoreticians and practitioners, the view that the sick care function, with respect to incapacitated elderly, has shifted to organizations outside the family (1, p. 59). As has been indicated, far more ill elderly are currently cared for at home than are resident in nursing homes and other institutions. Incapacitated older people who are prime consumers of long-term care may create social as well as financial stress for families. Where families exist and are locally resident they tend to act as guardians or caretakers of the diabled patient. The latent demand for long-term care can only suggest fiscal anxiety for public officials at state and national levels. Yet, within present policies and practices, integrated supportive services to families caring for elderly are minimal.

In the movement for increased involvement of consumers in policy and program development, can impaired older people and their families continue to be ignored by decision makers in light of an asserted desire for reform of present health delivery systems?

Planning for System Reform

Given the national goal, articulated by the President, of "helping older persons live dignified, independent lives in their own homes or residences--by expanding and reforming service programs" (11), then fresh policies and positive action strategies are required. To devise feasible alternate health delivery systems addressed to elderly confined at home suggests, among others, the following new directions for planning:

- Establish a more balanced use of public funds allocated to long-term personal care, assigning an equitable amount to services for impaired elderly at home in parity with support of institutional care.
- Integrate the joint concerns of public and private agencies and organizations for the elderly in the utilization of public and voluntary resources.
- Coordinate basic local health and social services under a single effective distributive mechanism at the community level.

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* Lieberman codifies a number of studies attesting to the deleterious effects of institutions on the behavior of the aged. He makes clear many of the negatives cited are associated with institutional life. What remains uncertain, however, is "whether life in the institution **induces** such effects" (writer's emphasis).

- Stabilize services for elderly at home or in residences by selecting a responsible agency as the local conduit for the new service delivery system.

- Incorporate measures of accountability and appropriate tests of service effectiveness to permit evaluation of attainment of pre-stated objectives.

- Assure representation from elderly and their families in planning, policy-making, and operational procedures of the local service programs.

In brief, to interrupt the flow of impaired elderly to institutions, new service systems addressed to maintaining older people in their homes should meet the criteria of accessibility, flexibility, responsibility, and accountability and function as a coordinative mechanism. One program of community-based services, designed to meet these five criteria, is entitled **community care for the elderly**. The program is conceptualized as an experimental, consumer oriented, mobile health service system which lends itself to testing the effectiveness of a community-based approach to provision of fundamental health and supportive services for impaired elderly at home requiring long-term care and assistance.

Community Care: An Alternative to Institutionalization

Community care for the elderly includes but is not necessarily restricted to five home-delivered basic service components, namely:

1. **Health maintenance**––provided essentially by registered nurses and other qualified health personnel working as a team, with physician consultation, to help confined older people maintain an appropriate standard of personal health care.

2. **Home help**––practical assistance provided regularly by trained aides to relieve unwell householders of such tasks as house cleaning, laundering, meal preparation, marketing for food supplies, and the routine demands of daily maintenance.

3. **Mobile meals**––dietician supervised, hot nourishing food delivered regularly to elderly unable to prepare meals.

4. **Transportation service**––vehicular service, designed to enhance the mobility of impaired elderly and improve the accessibility of physicians, clinics, health and social resources, and essential social services.

5. **Counselling, crisis and advocacy service**––provided under supervision of qualified social workers; aided by indigenous staff to ensure consumers that promised services are delivered, and responsive to emergencies around-the-clock.

Six reasons constitute the rationale for selection of particular program components subsumed in community care for the elderly. **First,** there was some generalizeable experience in the country recommending selection of these services (but few serious evaluations have yet been reported on service effectiveness). **Second,** apart from housing and income maintenance, the program packet seems to contain the basic components necessary for normal daily functioning. **Third,** the services selected tend to be those forms of assistance usually sought by elderly without family, from outside, frequently unstable, sources of aid. **Fourth,** judicious use of the service packet by family caretakers can enable family members to enter or re-enter the labor market if deemed in their own financial interests. **Fifth,** collective costs of proposed services and their administration was estimated to fall well below present average vendor payments to licensed nursing homes in most states. **Sixth,** the services proposed are likely to be found, or can be established with reasonable effort, in most urban areas of the country.*

* As additional funds become available, the concept of community care could be expanded gradually to include such services as occupational and physical therapy, portable dental care, health screening, mobile drug service, hearing aids, eye glasses, podiatry, provision or loan of specialized health equipment, assistance with housing location and relocation, etc., etc.

Summary

This presentation has chosen to focus on issues in long-term care services to help maintain impaired older people in their own homes. Current inequities in health care policies and practices tend to channel older people towards the institution while at the same time denying adequate resources to a home care program. Evidence from one study was cited to indicate that approximately one third of low income elderly admitted to nursing homes in one county in Florida could have postponed admission had essential health care services been made available in the community. Moreover, most older people with apparent health deficiencies prefer to remain at home with less service rather than enter nursing homes.

An alternate health care system addressed to elderly at home requiring long-term personal care, labeled community care, is proposed for test. Community care for the elderly is envisioned as an integrated package of locally based, user-oriented, basic set of services, orchestrated by a stable community agency with freedom to experiment in providing functionally impaired older people with a viable alternative to institutional care.

REFERENCES

(1) Bell, William G. **Filial Responsibility, Social Provision and Social Policy.** Unpublished Ph.D. Dissertation, Brandeis University, 1969.

(2) Bell, William G. **Community Care for the Elderly: An Alternative to Institutionalization.** Department of Urban and Regional Planning, Florida State University, June 1971.

(3) Brotman, Herman S. "The Older Population Revisited––First Results of the 1970 U. S. Census." **Facts and Figures on Older Americans.** U. S. Department of Health, Education and Welfare, Administration on Aging SRS–AOA Publication No. 2.

(4) Goldfarb, Alvin I. "Institutional Care of the Aged" in Busse, Ewald W. and Eric Pfeiffer (eds.) **Behaviour and Adaptation in Later Life.** Boston: Little Brown and Company, 1969.

(5) Henry, Louis H. "Caring for Our Aged Poor" **New Republic,** May 27, 1971.

(6) Lieberman, Morton A. "Institutionalization of the Aged: Effects on Behaviour." **Journal of Gerontology,** Vol. 24, No. 3, July 1969.

(7) A Report to the Delegates from the Conference Sections and Special Concerns Sessions. 1971 White House Conference on Aging. November 28 – December 2.

(8) Riley, Matilda White and Anne Foner (eds.) **Aging and Society,** New York: Russell Sage Foundation, 1968, p. 206.

(9) Shanas, Ethel, "Measuring the Home Health Needs of Aged in Five Countries" **Journal of Gerontology,** Vol. 26, No. 1, 1971.

(10) Steering Committee of National Voluntary Organizations for Services to Older Persons in Their Own Homes or Other Places of Residence. Processed, January 1972.

(11) U. S. House of Representatives, 92nd Congress, 2nd Session "Message from the President of the United States Transmitting Recommendations for Action on Behalf of Older Americans." Document 92–268 March 23, 1972.

(12) U. S. Senate, 92nd Congress, 1st Session. Special Committee on Aging. "Alternatives to Nursing Home Care: A Proposal." Prepared for the Committee by Levinson Gerontological Policy Institute, Brandeis University. Washington, U. S. Government Printing Office, October 1971.

(13) U. S. Senate, 92nd Congress, 1st Session, Special Committee on Aging. "A Pre-White House Conference on Aging, Summary of Developments and Data." Washington, U. S. Government Printing Office, November 1971.

(14) U. S. Senate, 92nd Congress, 2nd Session, Special Committee on Aging, "Home Health Services in the United States." Washington, Government Printing Office, April 1972.

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STRATEGIES IN PROVIDING SERVICES TO THE ELDERLY

Carter Osterbind

Our objective is to consider strategies for the economic use of resources in the provision of services, particularly strategies for the development and utilization of resources to meet the needs of older people. A clear and precise use of the term "strategy" will assist in our deliberations. The term has several meanings, but I believe the most appropriate definition is "the art and science of employing cultural, political, economic, psychological, and physiological forces to support effectively adopted and proposed policies pertaining to plans and stratagems toward a goal." This detailed definition is employed to emphasize the fact that programs to provide services should embrace the use of the social, behavioral, and physical sciences as well as the art of gaining acceptance for and implementing highly subjective ideas which cannot be tested by scientific processes.

Two similar terms, "economic use" and "development," have been used. The term "economic use" relates to providing a service under an existing program or arrangement; the term "development" relates to providing a service in a changed form or under changed conditions. There can be many gradations changing the service itself or the conditions under which it is provided. Later in the discussion attention will be given to the concept of "resources."

Let us examine one area of services, health care, in order to illustrate what is meant by "strategies" in providing services to the elderly. There is much evidence that in our efforts to develop the more effective use of health care resources we have on occasion lost sight of the dimensions of the problems. Health care encompasses more than medical care when it is defined only in terms of providing treatment for acute or chronic psychological and physical disease. Medical care is the root of health care, but its ramifications must be identified if resources are to be apportioned in an effective manner.

When we speak of the economic use of resources, we must keep in mind our frame of reference. The time period and other conditions under which health care service is to be employed must be a part of our definition of a strategy to use resources effectively. We will deal with these conditions more explicitly when we discuss problems and goals.

While we have no precise definition of the "elderly," we are primarily concerned with people in the sixty-five and older age group. The attributes of people in this age category are quite diverse, as are their health needs. Although there are reasons for focusing only on the health care needs of the elderly, planning many aspects of health care requires a broader focus.

Goals

Long-Term Goals. In the Administration on Aging's report on **Physical and Mental Health** is the following: "A long-range goal, deeply imbedded in our value system is that all Americans should enjoy the best physical and mental health and social well-being that knowledge and technology can provide. This goal——stated implicitly or explicitly——underlies the enormous expenditures we make for medical research, training health manpower, and for support of a huge conglomerate of health and medical facilities, programs, and services." The report points out also that Title I of the Older Americans Act sets forth four long-range objectives pertaining to health of

older people: (1) the best possible physical and mental health that science can make available without regard to economic status; (2) full restorative services for those requiring institutional care; (3) retirement in health, honor, and dignity--after years of contribution to the economy; and (4) immediate benefit from proven research knowledge which can sustain and improve health and happiness.

The statement of goals in the background and issues paper and the long-range goals under the Older Americans Act give us the direction in which we should work. It is important, however, that we consider these not only as long-range goals but also as continuing objectives. We need these types of goals and a commitment to them; however, as a basis for confronting many immediate problems, we need to identify goals that can be defined in terms of such problems.

In this treatment of the concept of strategy, we are led to the realization that we are really talking about social planning. Thus our strategy is to employ social planning in the health care field.

Goals in Social Planning. Morris and Binstock in **Feasible Planning for Social Change** have observed, " 'Planning,' as commonly understood, presents few conceptual difficulties. Planning is a relatively systematic method which men use to solve problems. We call those who use this method 'planners.' When planners have identified what they would regard as a solution to their problem, we call that a 'goal.' " The authors hasten to add that ". . . when we attempt to transform this everyday term into a more exact definition that will include the kinds of actors, the kinds of problems, and the variables, it is a formidable task."

Morris and Binstock stress that it is the informed basis on which the planner intervenes and seeks to attain goals that distinguishes planning from other approaches to problem solving. The identification of goals (the solution to problems) by the planner requires choices among alternatives. Thus, in planning it is assumed that ". . . at least some of these choices are guided by knowledge of the dynamic relationships between a given problem and alternative solutions to it--as understanding of cause and effect, action and reaction, and means and end."

Planning and effective use of resources in the health care field confront us with many types of problems. Prominent among these are the need to change laws governing programs in the broad social welfare field such as in public assistance and in Medicare and Medicaid, in the need to change people's attitudes (for instance, the attitudes of the providers and recipients of health services toward accepting new methods of delivering health care), and in the need to modify the policies and programs of existing health care organizations and groups in order to profit best from their efforts. Within the context of the planning environment, the health care planner must pursue clearly defined goals.

The person or groups developing the strategy to provide the maximum utilization of health resources must establish some order of priorities which takes into account the health needs of older people. Important to the evaluation are the feasibility of the proposed plan and the seriousness of the problem the plan addresses. There is no simple way to arrive at the list of priorities for planning purposes.

The guidelines established by Morris and Binstock are helpful. The title of the book itself suggests something extremely important in the development of strategies, specifically the term "feasible planning." In directing attention to what is feasible, the authors mention an awareness of what can be done, of the people who can exercise the power to bring about the changes, and of the perceptiveness and skill of the planner in dealing with obstacles that stand in the path of the goals sought. They also make clear the need to understand the broad and complex character of the problems and to work from a broad base of knowledge and understanding.

Therefore, I think the challenge facing us in developing strategies to improve health care delivery systems is to gain an understanding of the systems and the resources that are available to us to improve and change the systems. Because the

environment in which one works is constantly changing, it may be necessary from time to time to redirect planning as a result of sweeping changes in legislation or of the development of new technology.

Planning Resources

National Research Program on Health Services. A broad program is being sponsored by the federal government to bring about improvements in health services in the United States. In 1968 the National Center for Health Services Research and Development was established in the U.S. Department of Health, Education and Welfare. It provides financial support and leadership in a national program of research, development, demonstration, distribution, utilization, quality, and financing of health services, facilities, and technical equipment. Through the center's program, it is hoped that innovations and improvements will be developed in organizing, delivering, and financing health services. The broadness of the program and the many types of research to which it gives attention indicate the complexity of the health care problem.

A perusal of the types of research in process under the national program and of the design of the research indicates the variety of the health needs. It also indicates the difficulty of finding answers to the most perplexing problem in the health care field--the inefficiency of the health care system itself. The extensive need for upgrading medical statistics, for formulations of new concepts, and for improvements in reporting systems becomes clear. The long-established use of the case method in medical practice has contributed to a very loose use of terminology and, quite frequently, to little appreciation of the value of statistical procedures.

Basic Knowledge to Plan Health Services. Within each area or community, planners and others interested in the improvement of the health care of the elderly need to work from a basic position which includes the following: (1) an understanding of the health care programs in the area and how they relate to governmental and private programs including those confined to, and those extending beyond, the community; (2) an understanding of research that is under way or that is needed, in terms of its usefulness and applicability to the local situation and the most useful methodological approach to the study of local problems (for example, many research programs need to be replicated or complemented by similar or related types of research); (3) an awareness of the need to discover and identify problems that have feasible solutions; (4) a recognition that value judgments must be an important part of the decision process but that they must be based on the best information available or that can be obtained through research. One of the continuing problems in the health care field is the lack of communication not only within local areas but also among areas and agencies which can produce these data.

Local Planners' Participation in National Planning. Efforts to bring about the maximum utilization of health resources may involve attempts to change essentially all facets of health care practice in the nation, or they may be directed at particular problems that involve the behavior of individuals and the performance of established institutions.

At the present time, legislative proposals are being made to Congress to change or modify Title XVIII and Title XIX of the Social Security Act. Some of these proposals contemplate sweeping changes that may result in comprehensive benefits for Americans of all ages, while others seek to supplement or modify provisions of existing legislation. A study of health care legislation reveals that there are specific gaps in the services provided and that these gaps could be eliminated by specific changes--for example, changes concerning the noncoverage of out-of-hospital prescription drugs. I believe that it is important for everyone who is interested in improvements in health care services for older people to give careful attention to major legislative proposals now under consideration by Congress and to support actively the proposals which will eliminate the gaps that are creating the critical unmet health care needs.

A broad national health-insurance program is basic, I believe, to almost all types of health care

planning in local areas. It is important that we have a national health insurance program that recognizes the support that should come from all levels of government, from private institutions, and from individuals. All persons involved in community health care have important inputs to make. They can be advocates, can provide information, can obtain support from community leaders, and so forth. However, in community planning we must continue to seek goals to utilize more efficiently the existing programs and available resources by identifying specific conditions and problems that interfere with efficient utilization. Those who use this approach must recognize its subjective character and obtain sufficient information to evaluate the interaction of social relationships and the possibilities for bringing about greater efficiency. Within this more restricted frame of reference, let us identify some of the major health care problems that exist at the community level.

Health Care Problems in Urban Areas. In a large metropolitan area there may be as many as one thousand separate service agencies. Here is an opportunity for the planner to develop channels of communication and the coordination of program activities. Thus, the establishment of an information and referral service makes it possible more effectively to relate services to the users of the services. There are now three hundred information and referral services in the United States. The expansion and improvement of these programs offer many opportunities. A continuing important need in all areas is home health service. Prior to the passage of Medicare, there were few organized programs in the United States that provided home health care. At the present time, it is reported that two thousand home health agencies have qualified to participate in the Medicare program. There is a need to extend and improve programs of this type in order to make them more useful.

The need to provide ambulatory health service to individuals in low-income neighborhoods has prompted the establishment of neighborhood health centers. There is the need to know how effectively centers such as these can meet the health needs of the aged.

Recognizing that one of the major deficiencies in health care is health maintenance, health maintenance organizations have established programs to provide comprehensive health care. Such an organization can provide all types of services to the elderly on the basis of the prepayment of a fee to the providers of the service. Strong support should be given to demonstration programs to test further the merits of this approach.

Investigations have revealed serious deficiencies in nursing homes which indicate the need for improvements in administration and staffing as well as the need for resources to support adequate staff needs within the nursing homes. Until adequate financial support is obtained through the various support resources available, including Medicare and Medicaid, there is a continuing need to develop the best nursing home care the restricted resources will provide.

In every urban area the need for long-term care services is increasing. Health planners recognize the magnitude of the problem. There is a reluctance to incorporate these services in our national health insurance program, but the need must be met in some manner. The ill elderly person may require assistance in eating, bathing, dressing, and other routine activities over a considerable period of time. Broad national programs to meet these needs must be developed. In the interim, it is again necessary for local communities to bring every available resource into use to cope with these problems in the best possible way.

In the report on **Physical and Mental Health**, the health needs of older people are generally identified and discussed under four needs categories: (1) the need for improvement in the health of the aged, which the report discusses as "the need for a significant reduction in the amount of death, disease, disability, discomfort, dissatisfaction, and social disruption that [the elderly] experience as a result of illness, injury and the process of aging itself;" (2) "the need for adequate development and provision of certain types of health services--with special emphasis placed upon preventive services;" (3) "the need for a system (or a systematic way) to adequately and

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effectively deliver the entire spectrum of the health services appropriate to the well as well as the ill older person;" and (4) the need "to eliminate the socio-economic barriers that interfere with the aged person's ability to get into the health service system."

Within these broad statements of need, the challenge is for an attack not only at the national level but also at all levels. Within urban areas, many of these needs can be met. It is easy for us to prepare extensive lists of the health care problems. Many are common to most urban areas; but it is important that we avoid a stereotyped approach, that we work within the frame of reference we have described, and that we continue to experiment and to innovate.

Resources Available for Planning. The resources available to the health care planner in a local area must be viewed in relation to his authority and the particular functions of his organization. The changes the planner wishes to make through the intervention process should be consistent with his authority and the functions of the organization he serves. He will be able to make the changes he desires when he is able to persuade those in authority to implement them. The resources available to the planner include everything he may use to accomplish his objective.

For example, he may take advantage of all existing research and demonstration. According to the White House Conferences report, **Physical and Mental Health**:

> The National Center [for Health] is supporting the creation, testing, and demonstration of prototype community health service systems, and at the same time is attempting to improve the components necessary for such systems through development of (1) new types of health services manpower to extend the effectiveness of doctors, (2) new financing arrangements, (3) ambulatory and inpatient health care programs designed to provide comprehensive services to all people, and (4) inter-institutional arrangements to link doctors' offices, hospitals, and other facilities and services for continuous care.

The planner may use local research to develop information about the community, the people being served, and the programs in process. He may obtain help from social, behavioral, and physical scientists and from experts in various professional fields and may use universities and other components of the educational network. He may consult with others engaged in similar programs and, in short, use all available sources of knowledge. However, one of the greatest resources available to the planner is his skill in discovering how these extensive and diverse resources may be used to achieve his goals. This includes his relationships to people, an understanding of human nature, and special insights into program operations.

Conclusion

The strategy in providing community services for the elderly is to develop local goals consistent with long-term national goals. National research programs make clear the complexity and difficulty of the problems. To discover and achieve these goals, social planning procedures must be employed. While these procedures require that a planner in a local area work within the context of his authority, he also has a responsibility to contribute to national planning so far as possible. In many instances, partial solutions at the local level do not depend on solutions at the national level. The resources available to the planner, therefore, commence with his personal resources and extend through his selection of the resources of others. Applying the first resource to the second constitutes "the art of employing cultural, social, political, economic, psychological, and physiological forces to effectively support adopted and proposed policies pertaining to plans toward a goal."

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